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A COMPARATIVE STUDY TO ASSESS THE PSYCHOSOCIAL PROBLEMS AMONG ADOLSCENTS OF SELECTED RURAL AND URBAN SCHOOLS OF KASHMIR

MR. NOORUL AMIN
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**A Comparative Study to Assess the Psychosocial Problems among
Adolscents of Selected Rural and Urban Schools of Kashmir**

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Message from the Desk of Editor

It gives me immense pleasure to welcome all to explore/publish/ comment in/on our journal, The International Journal of Indian Psychology (IJIP). There are a lot of challenges which the growing psychological face in the realms of basic necessities in life. Psychological thoughts can play a very distinct role in bringing about this change. One of the key objectives of research should be its usability and application. This journal attempts to document and spark a debate on the research focused on psychological research and ideas in context of emerging geographies. The sectors could range from psychological education and improvement, mental health, environmental issues and solution, health care and medicine and psychological related areas. The key focus would however be the emerging sectors and research which discusses application and usability in social or health context.

We intended to publish case reports, review articles, with main focus on original research articles. Over objective is to reach all the psychological practitioners, who have knowledge and interest but have no time to record the interesting cases, research activities and new innovative procedures which helps us in updating our knowledge and improving our treatment.

Finally, I would like to thank RED'SHINE International Publications, for this keepsake, and my editorial team, technical team, designing team, promoting team, indexing team, authors and well wishers, who are promoting this journal. With these words, I conclude and promise that the standards policies will be maintained. We hope that the research featured here sets up many new milestones. I look forward to make this endeavour very meaningful.

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ABSTRACT

Background: Psychosocial problems have been identified as the vital among adolescent students at particular times when they enter their period of adolescence and are in the secondary and senior secondary schools. These psychosocial problems affect an adolescent in wide variety of settings and cause deterioration of their mental and social health. There were very few studies that have been conducted on psychosocial problems among adolescent students comparatively in rural and urban areas, particularly in the age group of 12-19 years in Kashmir. **Objectives:** the main objective of the study is to assess the Psycho-social Problems among adolescents of selected rural schools using Youth Self Report. **Method:**

The study was conducted by using descriptive method of research design. The sample consists of 100 adolescent boys and 100 adolescent girls from selected schools of urban and rural areas. The convenient sampling method was used to select the participants for this study both in rural and urban schools of Kashmir vale. Moreover, the tool used for this study was Youth Self Report developed by Thomas M Achenbach and C.S Edelbrock. The principals of the selected schools were requested to grant Permission for data collection. Data was collected by using Youth self-report which has 70 negatively stated statements each having option of never, sometimes, often having 0, 1 and 2 as score respectively; thus having 140 maximum score. **Results:** Results of the study indicated that psycho-social problems were present in the adolescent of selected rural and urban schools. Adolescents of rural schools were more affected than the urban areas. There was significant association of baseline characteristics with psycho-social problems in rural area while as gender and type of family had no significant association with psycho-social problems of adolescents of selected urban schools. Female adolescents were more in percentage than males having impairment. Rural females had more Psychosocial problems than urban female adolescents. 60 % of Adolescents in selected rural schools were having Psycho-Social Problems and were said to be impaired and only 40% of the adolescents were well adjusted. 43% of Adolescents in selected urban schools were having Psycho-Social Problems and were said to be impaired and only 57% of the adolescents were well adjusted. The means and percentage of the Psycho-social problem score of adolescents of rural (60%, 40.75) and urban schools (43%, 34.80) it can be concluded that adolescents of the selected schools living in the rural areas particularly those studied have more Psycho-Social Problems as compared to the Adolescents in the selected schools living in the urban areas of Kashmir valley. There is significant difference between Psycho-social problems of female adolescents of urban and rural areas and have been statistically proved by t test having value of 2.76 thus $p < 0.05$.

Key words:

Psycho-social Problems, adolescents, rural schools, urban schools,

CHAPTER: I INTRODUCTION

Children Are Our Most Valuable Resource
Hobart Hoover

I am so mixed up and lonely.
Can't even make friends with my brain.
I am too young to be where I am going.
But I am too old to go back again.
John Prine, Rocky Mountain Time

The word Adolescence has been derived from the Latin word *adolescere* which means; to grow into adulthood. Wikipedia online encyclopedia, has also defined it as a transitional stage of physical and mental human development that occurs between childhood and adulthood. This transition involves biological (i.e. pubertal), social, and psychological changes, though the biological or physiological ones are the easiest to measure objectively. There is no single event or boundary line that denotes the end of childhood or the beginning of the adulthood or adolescence. Rather it is thought to be the passage from childhood into and through adolescence as composed of set of transitions that unfold gradually and that touch many aspects of individual's behavior, development and relationships. These transitions are biological, cognitive, social, and emotional.

World Health Organization [WHO] has defined Adolescence as the age group of 10-19 years. In India, adolescents (10-19 years) constitute 21.4 percent of the population, comprising one fifth of the total Population. Adolescent population in India during 1991 was 181,419,000 which are projected to be around 215,332,000 by the year 2016 (UNFPA, 2003).

“Adolescence” is a dynamically evolving theoretical construct informed through physiologic, psychosocial, temporal and cultural lenses. This critical developmental period is conventionally understood as the years between the onset of puberty and the establishment of social independence (Steinberg, 2014). The most commonly used chronologic definition of adolescence includes the ages of 10-18, but may incorporate a span of 9 to 26 years depending on the source (APA, 2002). The onset of adolescence and the beginning of adulthood vary from country to country but we can generally place adolescents to be persons within the ages of eight and eighteen. Those in the period of adolescence are referred to as adolescents or teenagers or simply as teens. The period of Adolescence is filled with intellectual and emotional changes in addition to other major biological and physical changes. It is a time of discovery of self and one's relationship to the world around himself or herself. Before we delve into the problems of adolescence, let us take some time to note the causes. It is important to the success of our discourse that we first understand what is happening to the teen physically, cognitively, and socially; before looking at how these affects teens.

Physical Development: During adolescence, teens experience rapid physical development at a speed unparalleled since infancy. Physical development includes; rapid increase in height and weight (seen earlier in girls than in boys), the development of secondary sexual characteristics (prominent among which is the onset of menstruation in girls and the growth of pubic hair), a continued brain development.

Cognitive Development: Adolescents usually possess greater thinking skills than infants. These advances in reasoning can be seen in the following areas;

- Developing advanced reasoning skills. These include the ability to think about multiple options and possibilities. It includes a more logical thought process and the ability to think about things hypothetically. It involves asking and answering the question, “what if...?”.
- Developing abstract thinking skills. These means thinking about things that cannot be seen, heard, or touched. Examples include things like faith, trust, beliefs and spirituality.
- Developing the ability to think about thinking in a process known as “meta-cognition.” Meta-cognition allows individuals to think about how they feel and what they are thinking. It involves being able to think about how one is perceived by others. It can also be used to develop strategies, also known as mnemonic devices, for improving learning.

Psycho-Social Development: There are five recognized psychosocial issues that teens deal with during their adolescent years. These include:

- Establishing an identity.
- Establishing autonomy.
- Establishing intimacy.
- Becoming comfortable with one’s sexuality.
- Making achievement.

These issues bring about such changes in youths as; spending more time with their friends than with their family, keeping a diary, locking up their rooms, become involved in multiple hobbies, become more argumentative, would not want to be seen with their parents in public etc.

Chronologic Definitions of Adolescence According to the Oxford English Dictionary, the original 1482 definition of adolescence referred to a period between childhood and adulthood that extended between ages 14 and 25 years in males and 12 and 21 years in females (Murray et al., 1989). Hall’s (1904) original conception of adolescence included both genders between the ages of 14 and 24 years. More recent definitions of adolescence vary depending on the source without much discussion of the reasoning behind the proposed chronology. In 1995 the Society for Adolescent Medicine (SAM) published a position paper on adolescent health research defining adolescence as the ages 10 to 25. The American Academy of Pediatrics (AAP) “Bright Futures” recommendations for pediatric preventive services identifies adolescence as the ages of 11-21 years (2015). The U.S. Department of Health and Human Services (USDHHS) “Adolescent and Young Adult Health Program” webpage defines adolescents as ages 10-19 and young adults as ages 20-24 (2015). The Center for Disease Control and Prevention’s Youth Risk Behavior Surveillance System is constructed using a high school sample, grades 9-12, rather than age (CDC, 2015). The U.S. Census Bureau uses

different constructs for the adolescent population dependent on the specific topic including 12-17 and 15-19 (U.S. Census Bureau, 2015). The World Health Organization (WHO) defines “adolescents” as individuals between 10 and 19 years, “youth” between 15 and 24 years, and “young people” between 10 and 24 years (Blum & Nelson-Nmari, 2004; WHO, 2015). Adolescent Sub-stages Obviously, tremendous developmental discrepancy exists between the ages of 10 through 25 years and therefore “adolescence” is generally divided into sub-stages. Theorists and clinicians have historically differed in their chronologic definition of these sub-stages. Nienstein et al. (2009), a frequently consulted clinical authority, designates early adolescence as approximately 10 to 13 years, middle adolescence as approximately 14 to 16 years, and late adolescence as approximately 17 to 21 years. Steinberg (2002) previously identified adolescent sub-stages as early (10 to 13 years), middle (14 to 18 years), and late (19 to 22 years), however more recent publications (2014) include youth up to 25 within the construct of adolescence. Elliott and Feldman (1990) described early adolescence as 10 to 14 years, middle adolescence as 15 to 17 years, and late adolescence as 18 years to the mid-20s. Other prominent researchers separate youth into early adolescence (10 to 14 years), late adolescence (15 to 19 years), and young adulthood (20 to 24 years) (Irwin, Burg, & Cart, 2002). Finally, Arnett (2000) proposed removing the ages of 18 to 25 years from “adolescence” all together in favor of a new distinct phase of human development, the “Emergent Adult.” Other nomenclature used to describe people in their early 20s include “youth hood,” “thesholders,” “twixters” and “adultescents” (Grossman, 2005). “Transitional age youth (TAY)” is a descriptor generally associated with disconnected adolescents and young adults at risk for poor developmental outcomes, particularly those aging out of state services (Mandarino, 2014; TAYSF, 2014). There is currently no accepted chronologic definition for transitional age youth; age ranges can extend from 14-29 years, however a frequently used designation includes the ages of 16-24 years (AAPD, n.d.; TAYSF, 2014).

Now let us have a look at the stages that are widely accepted as proposed by the Steinberg;

Early Adolescence (11-13 years); It has been said that adolescence begins in biology and ends in culture (Steinberg, 2014). This proposed definition uses both biology and culture as guides for the chronologic parameters for the first stage of this transitional process, “early adolescence.” Beginning with biology, the mean age for the onset of puberty is 11 years (APA, 2002; Grumbach & Styne, 1998). Certainly there are youth who experience puberty before age 11 and many who transition after the age of 11, but the group experience of puberty is inclined more towards 11 than it is the age of 10 or earlier. From a cultural perspective, a 10 year old is generally still rooted firmly within the elementary school environment whereas an 11 year old is making the transition to secondary education, middle/junior high school in America that more closely aligns with adolescent activities including increased freedom, more rigorous academic expectations, and early romantic attachments. Using the age of 11 as the boundary for entry into early adolescence is consistent with the American Academy of Pediatrics Bright Futures framework (2105) for preventative care services. The end of “early adolescence” in this definition is demarcated at age 13. From a biological perspective, a diagnosis of delayed puberty is made by the age of

14 in the absence of the development of secondary sexual characteristics (Dynamed, 2015; Rosenthal et al., 2002). In a cultural context, American youth generally leave middle/junior high school at the age of 13 and transition into high school (upper secondary education) at age 14, embarking on the full “adolescent” experience. Early Adolescent Development. Early adolescence is heralded by the onset of accelerated physical and sexual maturation. Accompanying psychosocial adjustment to pubescent changes evokes a pre-occupation with body image (Radzik, Sherer & Neinstein, 2002). The early adolescent brain experiences continued development of the pre-frontal cortex influencing cognitive ability; synaptic pruning, affecting coordination and efficiency of thought; and neurotransmitter changes implicated in mood, appetite and sensation-seeking predilections (Casey, Tottenham, Liston, & Durston, 2005; Barnes-Goraly et al., 2005, Luna et al., 2004; Steinberg, 2014). Cognitive function in adolescence evolves from the concrete “operational logic” of childhood to increasing “formal operations” and nascent abstract thought (Piaget & Inhelder, 2000). As the ability of abstraction increases, there is a shift from an objectivist perspective to a relativist orientation (Byrnes, 2003), and emergence of reflective thinking (Selman, 1980). The combination of mesocorticolimbic activity, pubertal hormonal changes, and multifaceted social stressors may cause the early adolescent to be increasingly susceptible to wide mood swings, emotional lability and reduced impulse control (Arnett, 1999; Buchanan, Eccles, & Becker, 1992; Neinstein, 2002; Spear, 2000; Rosenblum & Lewis, 2003). Social role development emphasizes “industry vs. inferiority,” a psychosocial orientation accentuating accomplishment (Erikson, 1968). Emotional conflict with parents escalates (Laursen, Coy & Collins, 1998) coinciding with a shifting emphasis to peer involvement (Bradford-Brown & Klute, 2003; Neinstein, 2002) predominated by unisex relationships with increasing interest in heterosexual group contact (Bouchey & Furman, 2003). There is an amplification of overt sexual curiosity and experimentation possibly related to adrenarche and gonadarche (Harrison, 2003; Radzik, Sheres, & Neinstein, 2002). First awareness of same gender attraction for gay and lesbian youth often occurs during early adolescence (Anhalt & Morris, 1998; Pew Research Center, 2013). Morality generally functions at a “conventional” level, preoccupied with social norms and expectations, moving toward an appreciation for relational ethics (Kohlberg, 1980; Nucci, 2001). An understanding of social equity shifts from strict adherence to equal treatment to a more individualized appreciation of human need (Nucci, 2001). Faith ranges from the “literal-mythic” to the “synthetic-conventional” relying heavily on compliance with the beliefs of influential others (Fowler & Dell, 2004). In the American academic setting, the early adolescent usually transitions from the nurturing nest of a single educator primary school environment to a middle/junior high school context. Generally, the new academic system incorporates a variety of educators and reduced teacher- student relationships, stricter social controls with more punitive consequences, and a more competitive grading structure with increased academic demands (Eccles & Buchanan, 1996; Eccles et al., 1993; Fenzel, Blyth & Simmons, 1991; George et al, 1992). Legally, the early adolescent remains highly dependent on adult authority. However at the age of 12 in some states the adolescent may consent autonomously for confidential health care services (English, 2002).

Middle Adolescence (14-17 years); all proposed definitions of adolescence, both current and historic, include the ages of 14-17, the high school years in the American education system. High school is a significant, often idealized and romanticized cultural phenomenon in western society (Modell & Goodman, 1990) portrayed throughout cinema in movies such as Grease, Mean Girls and Dead Poets Society. The lived experience of a high school student is qualitatively different in culture, expectations, exposures and opportunities than that of a middle/junior high student or a high school graduate. Accordingly, the CDC uses high school, grades 9-12, as the sampling frame for adolescent health indicators (CDC, 2015). Using a scholastic cultural framework, movement from early adolescence begins at the average age of entrance into high school at age 14 and ends at age 18, generally coinciding with graduation from secondary education and the most common age of legal majority in western cultures (UNICEF, 2015). Although other western countries employ varying constructs for secondary education, all include the ages of 14-17 with compulsory education generally mandated until the age of 16 (NCES, 2015). From a developmental perspective, the age of 14 years is considered a significant psychosocial benchmark. It is widely purported in the developmental literature that at age 14 an adolescent demonstrates the “ability” to maintain adult reasoning patterns (Petersen & Leffert, 1995). “Ability” for adult reasoning is differentiated from reasoning “capacity” which is highly subject to life experience and other contextual factors (Petersen & Leffert, 1995; SAM, 2003). The reasoning mechanisms of adolescents have been found to fluctuate considerably in response to contextual forces such as peer influence (Petersen & Leffert, 1995; Steinberg & Scott, 2003; Dorn, Susman & Fletcher, 1995). An appreciation for developmental changes in reasoning ability supports a theoretical separation between the early adolescent (before age 14) from the older adolescent (after age 14). It is tempting to designate 14-17 as “middle” adolescence since the developmental transition is most frequently divided as a triad. However, this proposed definition does not use “adolescent” nomenclature for the ages of 18-25, therefore eliminating identification of a “middle” adolescent stage.

Late Adulthood (18 to 25 years); the final phase of the “adolescent” transition begins at the age of majority, accepted in most American states and internationally as age 18 (UNICEF, 2015). Exceptions in the U.S. are Alabama, Delaware and Nebraska where the age of majority is 19 years, and 21 years in Mississippi. Although in Mississippi an 18 year old may consent for health care (English, 2002; NCSL, 2015). In most cultures, reaching the age of majority imputes legal autonomy and an expectation of increasing social and economic independence. There is a categorical difference between opportunities, capabilities, and responsibilities in society before and after the age of majority. Therefore, any sub-division of adolescence combining pre-majority youth and post- majority youth is conceptually flawed. Age 18 also usually corresponds with graduation from secondary education in the U.S., another significant social indicator of movement away from childhood and into social maturity. In several American states graduation from high school is used as a legal criterion for reaching the age of majority (NCSL, 2015). The incorporation of the late teens and early 20s into the understanding of the transitional phase of “adolescence” reflects the most current perspective on physical and social development in youth. Although the 18-25 year old may appear complete in physical maturity, MRI research demonstrates that the frontal lobe and

limbic system of the human brain continue to develop through the late teens and possibly even into the early 20s (Beckman, 2004; Spear, 2000; Steinberg, 2014). Potentially related to continued brain development and combined with increased environmental exposures and progressive social independence, risk behaviors often peak during the ages of 18-25 (Arnett, 2002; Bachman et al., 1996; NAHIC, 2014).

Causes of Psychosocial Problems

There are various causes that lead to Psycho-social problems in adolescents, not only that but also affect psychosocial development. These are:

Poverty:

Poverty has a major negative psychosocial impact. According to studies by V.C. McLoyd, persistent exposure to poverty has a directly negative effect on a child's health, cognitive development and ultimately, their school achievement, particularly when poverty happens in infancy or early childhood. The more obvious explanation for the reasoning of this are that lifestyle and living conditions for those who live in poverty affect a child negatively. Environmental deprivation is usually what we consider when we think about poverty, but it is not the only factor. Stressors such as unsafe or life-threatening living conditions and violence play a part. Among these is deprivation of other essential necessities that are needed, such as food, medicine and a safe home. Deprivation of any of these things, especially in infancy or early childhood has a marked effect on psychosocial development. As McLoyd points out, children who live in poverty are exposed to more extreme living situations than those who are not living under similar circumstances. These conditions may have a more pronounced effect or influence on them. Studies have also shown that poverty has a direct effect on cognitive functioning and development, which has a direct impact on psychosocial development. If a child is unable to master the tasks that other children his/her age are, then their development may stall. Basically, poverty affects the physical, social, societal, and mental well-being of a child, therefore, its far-reaching effect can be devastating to the development of a child.

Cultural Values and Societal Roles

It may not come as a surprise that a person's gender or cultural heritage can shape who they are and what they do in life. It also affects psychosocial development in positive and negative ways. A study of ethnic-racial socialization in early and middle childhood found that cultural socialization was associated with fewer behavior problems in both genders (Hughes). Discrimination of cultural values or ethnicity has a negative effect (depression and aggression) on psychosocial development and behavior. It also effects self-esteem, academic achievement, stigmatization and psychosocial functioning. There is a need for more research on the effects of these particular issues on development, as very few studies have been done and little empirical evidence exists.

Abuse or Neglect

It could hardly come as a surprise that abuse and neglect causes poor performance in a school setting. But many people do not understand why that is exactly. A study by Eckenrode, Laird and Doris showed that maltreated children tended to have test scores below that of peers who

were not maltreated. Their study even broke down results to show what type of maltreatment resulted in the poorest performance. Neglected children scored lower in many areas than even sexually abused children. The findings of the study also showed a significant increase in disciplinary action and suspension for maltreated children.

In terms of disciplinary action, students who were physically abused had the most instances of action. It could be easily concluded that students who are being mistreated at home, whether it be neglect, sexual or physical abuse, are more likely to perform poorly, halt development and have disciplinary problems in the classroom. Psycho-socially speaking, maltreated children struggle with impaired language development, less pro-social behavior, lower levels of cognitive maturity, more aggressive behavior and more insecure attachment to their mothers.

The Eckenrode study also concluded that students who are neglected perform at the lowest levels of academic achievement among any maltreated children. This is significant in terms of classroom management because it may not be as easy to spot neglect as it could be to see the signs of physical and sexual abuse. Another interesting finding of this study is that while gender did effect what type of abuse a student was likely to experience, it found no great difference between the genders in terms of the effects of maltreatment (with the exception that boys were more likely to have disciplinary problems. No matter what abuse a student suffers, it clearly impacts their psychosocial development and in turn, negatively impacts their education.

Family Dynamics

A study by Oshman and Manosevitz shows that the presence of an older male figure (such as that of a step-brother or step-father) can positively affect a child's development. Theoretically speaking, this presence could also affect them negatively if it were the case of an abusive relationship. As far as testing, students in the study tested much higher if they had a father figure present. The study also showed that an absence of this father figure early on in the child's life resulted in a negative effect on the child. According to studies of adolescent socialization in families by Steinberg, children whose parents were authoritative (warm and firm) showed high levels of competence and psychosocial maturity than peers who have more permissive, indifferent or authoritarian with their child (Steinberg 88). What this means to teachers of high school students is that we may notice a maturity and seriousness in students who have a disciplined home life and caring parents. It was also found that authoritative parenting can lessen the effect of negative peer influence.

Peer Influences

During the transition into adolescence, we tend to rely more and spend more time with peers/friends than any other group. These interactions are important for self-esteem, development and learning the hidden curriculum. Peers can however have both a positive and negative influence on adolescent development. As stated in the above segment, Steinberg found through a study that the effects of negative peer influence can be blunted by authoritative parenting. The major influence of peers on development is their contribution to identity development. This is because peers influence the way an adolescent may view

themselves and the world around them. Peers can effect self-esteem and establish norms for their peer group. Peer rejection can negatively impact psychosocial development, and so these established norms can delineate who is a desirable and undesirable peer. Very little research has been done in the function of teenage romantic relationships, but be assured that can effect development as well.

Mental Health

It might seem like an obvious cause of psychosocial dysfunction, but mental health can have a broad meaning. It can cover disorders but also emotional stressors that cause mental health issues. There is a correlation between stress and mental health, especially in young adolescents. In findings of a study by Roeser, adolescents who were well-adjusted or positively adjusted were less likely to affiliate with negative peers, skip school, exhibit at-risk behavior or have low self-esteem whereas parents of children with poor mental health were characterized as having low academic value and be more likely to associate with the above behaviors.

Physical Health and Malnutrition

Studies show that food insufficiency and malnutrition can affect not only physical development but also psychosocial development. A study by Katherine Alaimo, Christine Olson and Edward Frongillo Jr, analyzed data from nutritional surveys on US children and teenagers from age 6-16 years old. The results of their study were that the children who were food-insufficient had significantly lower scores in arithmetic and were more likely to have to repeat a grade, see a psychologist and have trouble associating with peers. Making sure that children are getting the proper nutrition and exercise or activity is vital to their success in the classroom (and of course, their livelihood).

Disabilities

Physical and learning disabilities can effect psychosocial development as well. Research on children with learning disabilities found a negative correlation with self-esteem, interpersonal relationships and juvenile delinquency (Pickar). It is suggested by older research that due to a negative educational experience, some adolescents with learning disabilities may engage in delinquent activity as a way to satisfy frustrated emotional needs that are not being met in other ways. There also seems to be high correlation school failure and delinquency in these cases. This could be the result of negative self-concept. In Pickar's findings, adolescents with learning disabilities showed less resolution of the industry vs. inferiority stage. This could be attributed to perceived popularity and low self-esteem.

Stress

Stressors for adolescents can include any of the above problems and more. It is important to note the fragility of the emotional state of children this age. According to Roeser, studies show that if adolescents perceive themselves as competent academically, they generally get higher grades and are able to master school-related tasks more easily. There is a correlation between emotional distress and impaired ability to learn. Results from other studies on

emotional distress in early adolescents find that it can have an effect on academic motivation and achievement.

NEED FOR THE STUDY:

There is A Reason behind Everything in Nature.

Aristotle

Adolescence is a period of marked change in the person's cognitive, physical, psychological, and social development and in the individual's relations with the people and institutions of the social world. Adolescence is the one of the most challenging times of one's life. Having to deal with a roller coaster of emotions, often times hormonally induced becomes the day for both the parents and the teenager.

Psychosocial problems, such as behavioral, emotional, and educational problems, are highly prevalent among children and adolescents. Early treatment may reduce these problems, if accurately identified. Validated questionnaires may support identification. The need of this study is to assess the psychometric qualities of such a questionnaire, the Short Indicative Questionnaire for Psychosocial problems among adolescents and early detection of psychosocial problems among adolescents.

A study revealed the relationship between adolescent peer groups and incidence of psychosocial problems in 127 samples, 13–17 year old adolescents in a treatment group and 114 age-matched controls. A content analysis resulted in 4 separate types of peer groups. The group with the lowest level of involvement in school activities was labeled by other adolescents in negative terms. The least involved and most negatively labeled group generally had the most positive attitudes toward alcohol and drug use (ADU), the lowest levels of perceived harm due to ADU, and the highest levels of ADU, delinquency, and depression. This group also had the lowest level of self-esteem, most external locus of control, least perceived access to occupational opportunities, and highest level of societal estrangement. Results are interpreted as providing support for both control and labeling theories.

The problem of adolescence is by no means an easy topic to discuss notwithstanding that it is so to speak an everyday thing. It is often said that the teenage years are the “best years of one's life”, In fact Art Linkletter a Canadian born US broadcaster in his book *A Child's garden of Misinformation* highlighted the beauty of the adolescent years in this famous quote; The four stages of man are infancy, childhood, adolescence, and obsolescence, in his opinion, life became useless after adolescence. As true as these assertions may be, it is ironic to note that this is only part of the picture. Life for many adolescents is a painful tug of war filled with mixed messages and conflicting demands from parents, teachers, friends, family and oneself. Growing up—negotiating a path between independence and reliance on others—is a tough business and that summarizes what we would be discussing here today. Changes which the teen is undergoing, they become vulnerable to many forms of trouble. As adolescents try new behaviors, they become vulnerable to injury, legal consequences, and sexually

transmitted diseases, unwanted pregnancies, traumatic injuries, particularly from car and motorcycle accidents, etc.

We shall then proceed to discuss some of these problems.

BEHAVIOURAL PROBLEMS

Adolescence is a time for developing independence. Typically, adolescents exercise their independence by questioning their parents' rules, which at times leads to rule breaking. It is common for once loyal children to begin to grumble when asked to carry out some chores at home and to respond in harsh words when been rebuked by their parents. This is often a challenging time for most parents. Some parents and their adolescents clash over almost everything. In these situations, the core issue is really control—adolescents want to feel in control of their lives and parents want adolescents to know they still make the rules. Children occasionally engage in physical confrontation. However, during adolescence, the frequency and severity of violent interactions increase. Although episodes of violence at school are highly publicized, adolescents are much more likely to be involved with violence (or more often the threat of violence) at home and outside of school. Many factors, including developmental issues, gang membership, access to weapons, substance use, and poverty, contribute to an increased risk of violence for adolescents. Of particular concern are adolescents who, in an altercation, cause serious injury or use a weapon. Because adolescents are much more independent and mobile than they were as children, they are often out of the direct physical control of adults. In these circumstances, adolescents' behavior is determined by their own moral and behavioral code. The parent guides rather than directly control the adolescents' actions. Adolescents who feel warmth and support from their parents are less likely to engage in risky behaviors. Also, parents who convey clear expectations regarding their adolescents' behavior and who demonstrate consistent limit setting and monitoring are less likely to have adolescents who engage in risky behaviors. Authoritative parenting, as opposed to harsh or permissive parenting, is most likely to promote mature behaviors. Substance abuse is a common trigger of behavioral problems and often requires specific therapy. Behavioral problems may be the first sign of depression or other mental health disorders. Such disorders typically require treatment with drugs as well as counseling. In extreme cases, some adolescents may also need legal intervention in the form of probation which is not so common in Nigeria.

SEXUALLY TRANSMITTED DISEASES (STDs) OR UNWANTED PREGNANCY

This is as much a problem for the male adolescent as it is for the female but generally, the girls stand a greater risk of this. Due to the development of secondary sexual characteristics following adolescence, teens feel a great push to explore and experiment with their bodies. Early maturing girls are likely to start dating and a combination of the overwhelming urge to explore and peer pressure leads many into sex. Teens often equate intimacy with sex. Rather than exploring a deep emotional attachment first, teens tend to assume that if they engage in the physical act, the emotional attachment will follow most sexually active adolescents are not fully informed about contraception, pregnancy, and sexually transmitted diseases, including human immunodeficiency virus (HIV) infection. As a result, many fall victims of unwanted pregnancies as well as STD's. This we must note has destroyed so many young

promising teens even from very good homes. Because adolescence is a transitional stage in life, pregnancy can add significant emotional stress. Pregnant adolescents and their partners tend to drop out of school or job training, thus worsening their economic status, lowering their self-esteem, and straining personal relationships. Some of them never get to fulfill their childhood dreams in life. Pregnant adolescents, particularly the very young and those who are not receiving prenatal care, are more likely than women in their 20s to have medical problems such as anemia and toxemia. Infants of young mothers (especially mothers younger than 15 years) are more likely to be born prematurely and to have a low birth weight. Also there is the problem of Vesico vaginal fistula (VVF). Most times, pregnant teens attempt abortion, but this does not remove the psychological problems of an unwanted pregnancy—either for the adolescent girl or her partner. Really, it leads to more psychological and medical problems and the church has very strong words against abortion. Parents may have different reactions when their daughter says she is pregnant or their son says his girlfriend is pregnant. Emotions may range from apathy to disappointment and anger. It is important for parents to express their support and willingness to help the adolescent sort through his or her choices. Parents and adolescents need to communicate openly about sex, contraception, abortion, adoption, and parenthood which are all tough options for the adolescent to struggle with alone.

DRUG AND SUBSTANCE ABUSE

Substance use among adolescents occurs on a spectrum; from experimentation to dependence. Experimentation with alcohol and drugs during adolescence is common. Unfortunately, teenagers often don't see the link between their actions today and the consequences tomorrow. They also have a tendency to feel indestructible and immune to the problems that others experience. Alcohol is the biggest culprit in this regard. Teens have access to it at parties, can obtain it from older friends who are of legal age to buy it, or may simply raid their parents' liquor cabinets. Moreover, unlike drug use, the moderate use of alcohol is considered perfectly acceptable in most adult social circles. Teens see their parents enjoying a cocktail after work or having a glass of wine at dinner. Drinking comes to represent a very sophisticated and adult thing to do, after all, mum and Dad do it...why shouldn't I? Using alcohol and tobacco at a young age has negative health effects. While some teens will experiment and stop, or continue to use occasionally, without significant problems. Others will develop a dependency, moving on to more dangerous drugs and causing significant harm to themselves and possibly others. Teenagers at risk for developing serious alcohol and drug problems include those: with a family history of substance abuse, those who are depressed, those who have low self-esteem, and who feel like they don't fit in or are out of the mainstream. The majority of adults who smoke cigarettes begin smoking during adolescence. If an adolescent reaches the age of 18 to 19 years without becoming a smoker, it is highly unlikely that he will become a smoker as an adult. An estimated 20 million adults in the United States abuse alcohol. More than half of these alcoholics started drinking heavily when they were teenagers. Teenagers abuse a variety of drugs, both legal and illegal. Legally available drugs include alcohol, prescribed medications, inhalants (fumes from glues, aerosols, and solvents) and over-the-counter cough, cold, sleep, and diet medications. The most commonly used illegal drugs are marijuana (pot), stimulants (cocaine,

crack, and speed), opiates, heroin, and designer drugs (Ecstasy). Drug use is associated with a variety of negative consequences, including increased risk of serious drug use later in life, school failure, and poor judgment which may put teens at risk for accidents, violence, unplanned and unsafe sex, crime and suicide. Parents can prevent their children from using drugs by talking to them about drugs, open communication, role modeling, responsible behavior, and recognizing if problems are developing.

STRESS AND DEPRESSION

Stress and depression are serious problems for many teenagers. A 1986 study in High Schools in Minnesota, in the US showed that although 61 percent of the students are not depressed and seem to handle their problems in constructive ways, 39 percent suffer from mild to severe depression. These young people often rely on passive or negative behaviors in their attempts to deal with problems. (Garfinkel, et al., 1986). Stress is characterized by feelings of tension, frustration, worry, sadness and withdrawal that commonly last from a few hours to a few days. Depression is both more severe and longer lasting. Depression is characterized by more extreme feelings of hopelessness, sadness, isolation, worry, withdrawal and worthlessness that last for two weeks or more. Young people become stressed for many reasons. The most common of these are: Break up with boy/girlfriend, increased arguments with parents, Trouble with brother or sister, increased arguments between parents, Change in parents' financial status, serious illness or injury of family member, and Trouble with classmates. In addition, Children from single parents or broken homes are subjected to a near harrowing experience which brings about Stress and Depression. A classic example of what life could be for a teen from a broken home is shown in my novel *Whispering Aloud* published by Spectrum books Nigeria (2007), you might wish to grab a copy. These stress inducing events are centered in the two most important domains of a teenager's life: home and school. They relate to issues of conflict and loss. Loss can reflect the real or perceived loss of something concrete such as a friend or money, and it can mean the loss of such intrinsic things as self-worth, respect, friendship or love. Young people respond to stress and depression by exhibiting much more anger and ventilation; being passive and aggressive. They yell, fight and complain just about everything. Drinking, smoking and crying more often- especially the girls- are other popular signs. They are also less inclined to do things with their family or to go along with parents' rules and requests.

Ultimately, most young people will develop and assume the responsibility for their own protection and peace of mind. But during the years of learning and practice, parents, teachers and helping adults need to be aware of the signs and patterns that signal danger. Awareness of adolescent stress and depression opens the door for adults to begin constructive interventions and stimulate emotional development.

BULLYING

This is a huge problem that exists among adolescents though it is often neglected in this part of the world. Bullying is the act of intentionally causing harm to others, through verbal harassment, physical assault, or other more subtle methods of coercion such as manipulation. Bullying in school and the workplace is also referred to as peer abuse. In colloquial speech,

bullying often describes a form of harassment perpetrated by an abuser who possesses more physical and/or social power and dominance than the victim. The harassment can be verbal, physical and/or emotional. Every day thousands of teens wake up afraid to go to school. Bullying is a problem that affects millions of students of all races and classes. Bullying has everyone worried, not just the kids on its receiving end. Yet because parents, teachers, and other adults don't always see it, they may not understand how extreme bullying can get. Studies show that people who are abused by their peers are at risk for mental health problems, such as low self-esteem, stress, depression, or anxiety. They may also think about suicide more. Bullies are at risk for problems, too. Bullying is violence, and it often leads to more violent behavior as the bully grows up. It's estimated that 1 out of 4 elementary-school bullies will have a criminal record by the time they are 30. Some teen bullies end up being rejected by their peers and lose friendships as they grow older. Bullies may also fail in school and not have the career or relationship success that other people enjoy. Some bullies actually have personality disorders that don't allow them to understand normal social emotions like guilt, empathy, compassion, or remorse. Such teens need help from a mental health professional like a psychiatrist or psychologist.

SCHOOL PROBLEMS

The School constitutes a large part of an adolescent's existence. Difficulties in almost any area of life often manifest as school problems. School problems during the adolescent years may be the result of rebellion and a need for independence. Less commonly, they may be caused by mental health disorders, such as anxiety or depression. Substance use, abuse, and family conflict also are common contributors to school problems. Sometimes, inappropriate academic placement—particularly in adolescents with a learning disability or mild mental retardation that was not recognized early in life—causes school problems. Particular school problems include fear of going to school, truancy, dropping out, and academic underachievement. Problems that developed earlier in childhood, such as attention deficit/hyperactivity disorder (ADHD) and learning disorders, may continue to cause school problems for adolescents. Between 1% and 5% of adolescents develop fear of going to school. This fear may be generalized or related to a particular person (a teacher or another student) or event at school (such as physical education class or bullying). The adolescent may develop physical symptoms, such as abdominal pain, or may simply refuse to go to school. School personnel and family members should identify the reason, if any, for the fear and encourage the adolescent to attend school. Adolescents have a delicate innocence that can be easily influenced, traumatized and subsequently destroyed by what they see, listen, do in and around them. Thus psychosocial problems knock at the door step of the adolescents as they have imbibed something negative, it becomes almost impossible to change them and they don't just imbibe, they often also go ahead to 'innocently' experiment, destroying their lives and those of their friends in the process. It is worth to mention here that there is simply no excuse for letting the physical and psycho-social changes of adolescence overwhelm adolescents so much as making you begin to take part in antisocial behaviours, unethical, immoral, irreligious activities and behaviours.

[Excerpts of a lecture delivered by Dr Ifedigbo Nze Sylva at the 2008 Annual Knights of St. John International Cadets and Junior Auxiliaries Convention holding at the KSJI Temple, Our Lady Queen of Nigeria Pro-Cathedral Garki –Abuja on Thursday August 28, 2008.]

Adolescents suffer from psychosocial problems at one time or the other during their period of growth and development. Many of these problems are of transient nature and often not noticed. Further, children may exhibit these problems in one setting and not in other (Ahmad et al., 2012). Most of the epidemiological surveys on school going children and adolescents have reported wide variation (17 – 45%) in the prevalence of psychosocial problems (Anita et al., 2003, Arun & Chavan, 2009). Studies have found that 3-9% of teenagers meet criteria for depression at any one time and at the end of adolescence, as many as 20% of teenagers report a life time prevalence of depression (Zuckerbrot and Jensen, 2006). Maharaj et al, 2008 noted that females were 1.7 times as likely to be depressed when compared to males. Those who were not living with both parents were 1.5 times as likely to be depressed as those who were living with their parents. Suicidal behaviour amongst adolescent students is a matter of great concern due to the tragic loss of prime years of life it entails. In the last two decades, official figures of suicide rate have increased from 7.9 to 10.3 per one lakh adolescents. The actual number is understandably more than that reported official figures, as non-reporting, under-reporting, and misclassification are prevalent due to various socio-cultural stigmas, religious sanctions, legal issues and insufficient registration systems (Vijaya kumar, 2007). Although research has been inconclusive, some findings have indicated that excessive indulgence in electronic communication, negatively affects adolescents' social development, replaces face to face communication, impairs their social skills, and can sometimes lead to unsafe interaction with strangers (Pew Internet & American Life Project, 2007).

The term psychosocial reflects both the under controlled, externalizing or behavioral problems such as conduct disorders, educational difficulties, substance abuse, hyperactivity etc and the over controlled, internalizing or emotional problems like anxiety, depression, suicidal ideation, phobias etc. The emotional problems have been relatively neglected compared with behavioral problems because these are not easy to be detected by the parents or teachers. Nowadays, because of rapid industrialization and urbanization majority of young couple are employed and live in unitary setup, so unavoidably they get less time to look after their children. Under these circumstances, psychosocial (emotional and behavioral) problems and psychiatric problems are on the rise. The changing social values and excessive electronic media influence altering the pattern of interpersonal relationships also add to the problems (Ahmad et al., 2012). To achieve full potential of young children, diagnosing psycho social issues at right time is a must. The combination of ignored psychosocial problems and the lack of mental health services in our country amplify the risk of precipitating academic underachievement and rising delinquent behaviors in adolescents. So there is needed to raise public awareness about the prevalence of these often hidden emotional disorders in Indian adolescents. In view of above current school based study was planned to understand the extent, nature and factors associated with adolescent psycho social problems of an urban area and the impact of a brief psychological intervention of the problems.

It is surprising to note that there are only few studies about male adolescent psychosocial problems from India. Most of the epidemiological survey on school going children and adolescents have reported a wide variation (20-33%) in the prevalence of psychosocial problems. Individual studies illustrated the prevalence of psychosocial problems ranging between 10-40%.

The Ministry of Health and Family Welfare, Government of India, invited “research proposals for funding as part of the ongoing National Mental Health Programme (NMHP) which aims at providing community based mental health care using the existing public health infrastructure. The proposed research should be relevant and translational in nature, i.e., it should conform to the aims/objectives of the NMHP and should translate into more effective/cost effective mental health interventions/service delivery”. This Rs 10 crore (US\$ 22.2 million) is an unprecedented research support to the NMHP for “phased implementation of the District Mental Health Programme, strengthening of medical college departments of psychiatry, modernization of mental hospitals, focused IEC initiatives, research and training”. Commencing with the first epidemiological studies at Bangalore in the 1950s and at Agra in the early 1960s, the Indian Council of Medical Research (ICMR) has been in the forefront of mental health research. The other major studies include the multi centered research cum intervention project titled “Severe Mental Morbidity” in four centers. The “Strategies for Mental Health Research”, based on six task forces that identified research priorities in mental health in 1980 was a major milestone. Two of these task force projects focused on acute psychosis and course and outcome of schizophrenia. Findings of the studies have not only influenced mental health care in India, but contributed to the inclusion of acute psychosis as a separate diagnostic category in International Classification of Diseases (ICD) 10th Edition, of the World Health Organization. Other studies were mental health care of the aged and child psychiatric problems. Many of the trainees who participated in the community mental health training programmes initiated their own community mental health projects. These initiatives demonstrated both the need for research support to the developing NMHP (formulated in 1982) as well as the willingness of professionals to work as teams. The 1980s also saw the Council set up Advanced Centers for Research on Community Mental Health at Bangalore, Mental Health of Aged at Madurai, and Biological Psychiatry at Lucknow – all of which demonstrated how research support can help develop mental health services. The ICMR also supported research into the mental health aspects of disasters like the Bhopal Disaster in the 1980s, the Marathwada earthquake in the 1990s and the most recently Gujarat earthquake and the fire tragedy in Delhi. It is largely the result of these efforts that following any disaster in India, psychosocial support is readily provided to the survivors along with other services. At the International level, the World Health Report 2001 on Mental Health has been a landmark in the development of policies and programmes relating to mental health in the world and specifically in developing countries. The Report provides a framework for countries with different development levels to initiate actions appropriate to their resources. Already there is evidence of change in many countries. Another important document Neurological, psychiatric, and developmental disorders: meeting the challenges in the developing world, published by the Institute of Medicine in 2001 also focusses on the research needed to support mental health programmes in developing countries. The scope of mental health in the

new millennium should include care of the mentally ill persons, prevention of mental disorders and promotion of mental health as outlined by Dr Govindaswamy, the first Director of All India Institute of Mental Health (now NIMHANS), Bangalore over 50 year back: "Mental health in India has three objectives. One of these has to do with mentally ill persons. For them the objective is the restoration of health. A second has to do with these people who are mentally healthy but who may become ill if they are not protected from conditions that are conducive to mental illness which however are not the same for every individual. The third objective has to do with the promotion of mental health with normal persons, quite apart from any question of disease or infirmity. This is positive mental health. It consists of the protection and development of all levels of human society of secure, affectionate and satisfying human relationships and in the reduction of hostile tensions in the community." According to G. Stanley Hall (1904), Adolescence is a marvelous new birth, for the higher and more completely human traits are now born. Young adolescence a period of change more rapid than at any other time in human development other than infancy.

For the adolescent, this period is a dramatic challenge, one requiring adjustment to changes in the self, in the family, and in the peer group and also in the institution. Adolescents are one of the most vulnerable groups. A psychosocial problem is a strange event that is not easily understood. It is emotionally confusing and frightening and results in children needing significant instrumental and emotional support from adults. With the view of personal experience I felt the need to conduct this study is help to assess the psychosocial problems which will help in early detection of psychosocial problems among adolescents.

The recent studies estimated that only about 50% of the psychosocial problems of the children are identified by their primary physician or parents, 12-25% of all American school-age children have emotional/behavioral disorders. The psychosocial problems increased from 6.8% to 18.7%. Attentional problems showed the greatest absolute increase (1.4%-9.2%) and emotional problems showed the increase (0.2-3.6%). The percentage of children with attention deficit/hyperactivity problems receiving medications increased from 32% to 78%. These increase in psychosocial problems were associated with increase in the proportions of single-parent families, parents get divorced, mothers employment and parent child relationship.

At least 3% of school children suffer from serious emotional disturbances, such as depression, suicidal thoughts, psychosis and serious attentional problems. Attentional deficits and hyperactivity is the most common behavioral disorder of childhood. The prevalence of attentional deficits and hyperactivity among pediatric out patients in New Delhi was 11.2%. Sarkar, Kapur and Kaliaperumal (India) reported a prevalence rate of psychological disturbance of 10-54% in school going children of the age of group 8-12 years. The psychological problems found to be in 44% of the children. Anxiety related symptoms 67%, emotional problems, particularly depression 62% and conduct problems 49% were found. A big group of the population in any city/country is that of students and the life of students is becoming more and more stressful. Family is the nuclear of all social groups because of its functional importance of the child. It is where healthy habits are learnt by the

child. According to Tyrer and Tyrer(1974) absenteeism in the later years of schooling is predictive of depression in adulthood.

STATEMENT OF THE PROBLEM:

A comparative study to assess Psycho-social Problems of adolescents between selected Rural and Urban schools of Kashmir.

OBJECTIVES:

1. To assess the Psycho-social Problems among adolescents of selected rural schools using Youth Self Report.
2. To assess the Psycho-social Problems among adolescents of selected urban schools using Youth Self Report.
3. To Compare the Psycho-social Problems between adolescents of rural and urban schools.
4. To find the association between Psycho-social Problems of rural school adolescents and socio-demographic characteristics.
5. To find the association between Psycho-social Problems of urban school adolescents and socio-demographic characteristics.

OPERATIONAL DEFINITIONS:

Psycho-social problems;

In this study psycho-social problems refers the difficulties faced by adolescents in different areas of personal and social functioning such as somatic complaints, anxiety, depression, social problems, thought problems, attention problems, delinquent behavior, and rule breaking behaviors, aggressive behavior, internalizing and externalizing problems.

Adolescents;

In this study adolescents refer to both boys and girls who are in the age group of 12-19 years i.e teenagers that participated in the research as samples in rural and urban areas.

Rural Schools;

In this study rural schools refers to the schools which are located in the village premises of district baramulla. The schools that were selected in rural areas were working under government and private managements. These schools are;

Govt. hr. sec. school, chandilora Tangmarg

Govt. hr. sec. school, Lalpora, Kunzer

Iqbal memorial institute, Kunzer

Govt. high school Dhobiwan, Kunzer

Urban schools;

In this study urban schools refers to the schools which are situated in the city of Srinagar. The schools that were selected in urban areas were working under government and private managements. These schools are;

Govt. hr. sec. school soura, Srinagar

Govt. high school, Umerhair, soura, Srinagar

Galaxy Public Secondary school, 90 feet road soura, Srinagar

Population;

It refers to the adolescents in the age group of 12-19 years who are studying in the rural and urban schools of Kashmir excluding those who are not admitted in institutions for formal education.

Sample;

It refers to the adolescents who were selected to be the part of this research. The sample was in total 200 out of which 100 was from rural area [50 male and 50 female adolescents] and 100 from the urban area [50 male and 50 female adolescents].

Impaired;

Those adolescents securing a score of 36 and more than 36 on youth self-report.

Not-impaired;

Those adolescents securing a score of less than 36 on youth self-report.

Assumptions;

1. Adolescents face Psycho-social problems.
2. Psycho-social problems can be assessed by using a suitable tool like Youth Self Report.

Delimitations;

The study is limited to

1. Adolescents who are studying in the selected rural and urban schools of Kashmir.
2. Students studying in 8th, 9th, 10th, 11th and 12th standards.
3. Schools of district Baramulla and Srinagar.

Hypothesis;

H₁: There is no significant difference in the mean levels of Psycho-social Problems among the adolescents of selected rural and urban schools.

H₂: There is no significant difference in the mean levels of Psycho-social Problems among the female adolescents of selected rural and urban schools.

H₃: There is no significant difference in the mean levels of Psycho-social Problems among the male adolescents of selected rural and urban schools.

H₄: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of age.

H₅: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of gender.

H₆: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Type of Family.

H₇: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Family Income.

H₈: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Birth Order.

H₉: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of age.

H₁₀: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of gender.

H₁₁: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Type of Family.

H₁₂: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Family Income.

H₁₃: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms Birth Order.

CHAPTER: II

REVIEW OF LITERATURE

Nabanita C (2016): Adjustment Problems of Adolescence Girls- A Study on Kamrup District of Assam. Adolescence is the most important period of human life. It is considered to be the very special period of human life cycle. It is a period of rapid development which is important for the impact on the total development of human personality. The rapid physical development cause undue worries in both boys and girls. The present study was conducted to assess the problems of adolescent girls in the area of physical, social and emotional adjustments. A sample consisting of 300 adolescent girls 150 from co-educational Assamese medium school and 150 from co-educational English medium schools of Kamrup district (R) of Assam was taken for the study. R.K.Ojha Bells Adjustment Inventory and a self-devised questionnaire were used to collect data from the sample. The statistical measures adopted were: Mean, standard Deviation and t-test. The results revealed that there is no significant difference of problems of adjustment between the adolescent girls studying in English medium and Assamese medium schools. The main purpose of the study is to assess the problems of adolescent girls and to make a comparative study between adolescent girls of Assamese Medium School and English Medium co-educational School of Kamrup district (R) of Assam. Mean (M) and Standard Deviation (SD) and „t“-test was used to analyse the data. Findings reveal that there are some special problems which are faced only by the adolescent girls. The investigator tries to identify those problems with the help of a self-devised questionnaire.

Bista B, Thapa P, Sapkota D, Singh SB and Pokharel PK (2016); Psychosocial Problems among Adolescent Students: An Exploratory Study in the Central Region of Nepal. Recently, schools have drawn attention as dominant factors for psychosocial development of students. Nepal, however, has limited studies on this issue. This study sought to assess the prevalence of psychosocial dysfunction and its association with family-related factors among adolescent Nepali students. In this study 787 adolescent students from 13 schools of Hetauda municipality, comprised and accomplished a cross-sectional study. A set of structured questionnaire and Y-PSC was adopted to collect data, which were analyzed using SPSS with 95% of confidence interval. The results of this study revealed that One-fifth (17.03%) adolescent students suffered with psychosocial dysfunction. Male students (9.50%) were more affected, compared to female students (7.80%). The proportion of psychosocial dysfunction rose with the rise in age group and grade. Frequency of family dispute was significantly associated with psychosocial dysfunction OR = 13.24 (95% CI: 2.27–17.23).

Shankar B et al (2015): A study of psycho-social problems among adolescent students in pune, India. This study has revealed that psychosocial problems are present in adolescents as 328 children out of 2154 were at risk of developing so. This also revealed that gender and type of family does not affect psychosocial health. It also signified that children in government schools are at risk more than those studying in the private schools.

Rajkumar E, Sooraj K V, Sandeep B H, Harish C (2015); A comparative study to assessment the Psychosocial Problems among Students of Central University of Karnataka.

The results of the study indicated that there were no significant difference in the psychosomatic, anxiety/insomnia, and social dysfunction domains. But, in the dimension of Depression University boys found to have more depression than university girls that enter at college level.

Adhikari P, Nawaraj U, Matthew D et al (2015); Perceived behavioral problems of school aged children in rural Nepal: a qualitative study. The study revealed that the most common general problem of children in this community reported by the 72 participants of free list were economic problems (aarthik samasya)(N=51), not paying attention to (i.e., neglecting) school work (padhaima dhyan nadine) (N=48), involvement in addictive behaviors (kulat ma fasne)(N =46), family and households problems (gharayesi samasya) (N=40), getting angry easily and fighting over small issues (sano kurama risaune/jhagada garne)(N =31), disobedience (atteri) (N = 25), and stealing (chorne) (N =20). “Economic problems” included problems related to meeting basic requirements such as nutritious food, clothing, school materials and medicines. “Not paying attention to studies” included dropping out, irregular school attendance, lack of interest in education, not doing homework properly, skipping classes, always failing exams, roaming around during school hours, being more interested in playing than studying, and always watching television instead of studying. Family and household problems included having to spend too much time in household chores (such as cooking food, herding cow, goats etc.); not receiving proper care or supervision from parents as they are busy with work, having many siblings in the household, being orphaned, parents consuming alcohol and having disputes in the households; and not being allowed to participate in community activities. The five most reported behavior problems identified from free list interviews were; (*) not paying attention to studies, (*) involvement in addictive behaviors (i.e., consuming alcohol, cigarettes and marijuana), (*) getting angry easily and fighting over small issues, (*) disobedience, and (*) stealing.

Naik P K, Prasanta B, A Sutradhar (2015); A Comparative Study of Mental Health among rural and Urban Adolescent Students A sample size of 200 secondary adolescent students was selected and taken up for the study. General Health Questionnaires-28 (GHQ-28), developed by Goldberg and Hillier in 1979 used for the study. It is found that there are significant differences among rural and urban students.

Satinder D (2015); A Study of Youth Problems In Relation To Modernization. The present investigation was undertaken with an aim to study youth problems in relation to modernization. For this purpose 200 senior secondary school adolescents from Moga district of Punjab state were taken as a sample. The tools used were Youth Problem Inventory (YPI) by Km. Sandhya Sharma (1986) and Comprehensive Modernization Inventory (CMI) by S.P. Ahluwalia and A.K.Kalia (1985). Results showed no significant difference in the mean scores of youth problems of male and female students. The male and female students have the same means on their personal problems. The mean scores of female students in case of family, socio emotional and educational problems were more than their counterparts but this difference was statistically found non-significant. Further results revealed that no significant difference exists in the mean scores of urban and rural students. No significant difference was

found among students belonging to high modernized and low modernized groups regarding personal and family problems. Significant difference was found between the two groups in case of socio-emotional and educational problems. High modernized group has more socio-emotional and educational problems than the low modernized group students.

Jeena S, sojan B etal (2015); A Study of psychosocial problems in adolescent children in an urban area- pilot study report. The Current result is based on part of the study done in one of the school, as pilot report. The children were skeptical about the study initially. Significant more resistance was from the parents' side in enrolling their children for the study. However, the acceptance of the study procedure was fair following the sensitization lecture. All were from similar higher socioeconomic background with parents being highly educated (average 15.5 years of formal education). Out of 200 students eligible for the study, only 100 children responded (50%). Parents' responses were available for 45 (22.5%). There was no history of any significant illness among the participants or their family members. Though various subscales as well as total scores in both SDQ as well as PSC list were in normal limits for all the children, 38 students (38%) were noted to have significant distress over prior 6 months (reflected in impact score of more than 2 in SDQ). Surprisingly, none of the parents' report reflected any distress levels for their wards. 15 children (15%) expressed suicidal ideas during prior three months though none had made any suicidal attempts. 21 out of 38 distressed children (55.26%) attributed family issues as important factor for their distress. 30 children (78.94%) out of 38 distressed children complained of inadequate time spent with parents whereas only 18 (29.03%) out of 62 non distressed group complained about the same. 25 (25%) children had academic difficulties with significant difference between distressed and non-distressed children. 52 (52%) children reported spending time with electronic gadgets as preferred mean of relaxation. There were no significant differences among distressed or non-distressed group of children in use of electronic gadgets. There were no cases of addiction to internet or mobile. No significant male/female difference was noted among distressed and non-distressed children. Similarly no significant difference was observed among children living with one parent or both parents among distressed and non-distressed group. 20 children (20%) had used alcohol as experimentation, but none had substance use disorder. All distressed children were evaluated by psychiatrist (as the husband of principle researcher was psychiatrist) and were found not to have syndromic psychiatric disorder. The awareness about important adolescence problems was quite low among all children.

Waseem K (2014); study on stress among adolescents in Jammu and Kashmir. The purpose of this study was to differentiate the level of stress among adolescents of Kashmir valley. The obtained findings in the view of the hypotheses of the study have been discussed as follows. Finding of the present study was regarding to measure the level of stress among urban male and rural male and female showed significant difference between rural male and rural female groups adolescents. The stress of female adolescents are significantly higher than male adolescent. Some findings which consistent results Pradhan and Khalri (2001). Triveni and Aminobhavi (2002). Bena and Prolual (1992), Vema Kath (2009). Some finding which have contradiction results. Mitra and sen (1993), Bhagwan (1997), Barkal and Asma P. (1999). As

it was hypothesized in the research that there would be significant difference interims of level of stress in supported to hypothesized prediction. In this study it was found significant difference between rural male & urban female on the HR scale. Yoga, meditation, belief in religion are the upcoming sources acknowledged by science that could help the individual to build the personality that could convert stress into useful energy that could bring out more productive activities.

Surabhi C, Panna L and Harsavardhan N (2014); Prevalence of Depression among School Children aged 15 years and above in a Public School in Noida, Uttar Pradesh. The findings of this study has revealed that about 8% of children and adolescents suffer from depression and 11% of adolescents have a depressive disorder by the age of 18 years according to the National Co-morbidity Survey-Adolescent Supplement. This study has been conducted to estimate the prevalence of depression among adolescents studying in public schools in Noida in order to find out a relationship if any with different socio-economic and demographic factors. Cross-sectional study using simple screening instruments along with anthropometric measurements for detecting symptoms of depression in adolescents, two psychological instruments i.e. PRIME-MD PHQ-9 and perceived stress scale were used. Information on socio-demographic factors, activities undertaken to avoid depression and methods to relieve depression were collected using semi-structured questionnaires. Statistical analysis was done with Chi-square test using SPSS 17. Prevalence of depression was observed to be 38% among the study subjects in the age groups of 16 and 18 years. Males (35%) were found less depressed as compared to the females (41.8%). Association of frequency of going out for outing, extracurricular activities and type of activities and depression were statistically significant. Highest prevalence of depression was seen in obese (48.7%) study subjects. A statistically significant association was found between BMI and depression ($P < 0.003$). Majority of study subjects (36.6%) had consulted their parents, while 33% of study subjects had consulted their friends. Majority of study subjects (64.4%) listen to music to relieve depression which was statistically significant ($P < 0.001$). The study highlights the common but ignored problem of depression in adolescence. The teachers and parents should be made aware of this problem with the help of school counselors so that the depressed adolescent can be identified early and helped rather than suffer silently.

Rita R T, Rupali S D (2014): A Study on Aggression Level among Adolescents. Aggression has been defined as physical or verbal behavior (Baudra, 1993, Newman and Newman, 1997) intended to hurt someone- slaps, direct insults, even gossip dig (Myers, 1993) as a behavior directed towards another individual (Bushman and Anderson, 2001) in terms of violent, attacking and destructive behavior carried out with proximate, intent to cause harm (Berkowitz, 1993, Barron and Richardson, 1994, Bushman and Anderson, 2001) that results in pain to the victim. The present study aimed to find out aggression level among adolescents. A total of 60 adolescents (30male and 30female) from guwahati and sarthebari aged 14 – 16 were purposively recruited for the study, Aggression Scale developed by Dr.R.L Bharadwaj was administered to collect data. A significance difference was observed between male and female adolescents and adolescents from urban and rural area. The major findings of this study were that there is a significance difference in aggression among male and female

adolescents, the male adolescents are more aggressive than female in my studies. There is no significance difference in aggression among adolescents from urban and rural area. The male adolescents like to take in debating with others without need and they like much to hear and read story of revolutionary heroes than female adolescents. Female adolescents consider necessary to obey the rules of society than male. Many of female adolescents don't like to watch actions of violence in the programmes of Television.

Vaibhav J, Mayank S, Khursheed M, Jaivir Singh (2014); Prevalence of psychosocial problems among adolescents in rural areas of District Muzaffarnagar, Uttar Pradesh. The present cross sectional study was conducted to assess the prevalence of psychosocial problems among adolescents in a rural area. The study subjects were 210 adolescent girls and boys (10-19 years old) selected using multistage random sampling technique. The subjects were interviewed & detailed information was collected on a structured and pre-tested questionnaire after taking consent from the subject/ parents. The clinical diagnosis was generated as per the criteria laid down in ICD-10. The data was entered in Epi Info statistical software package Version 3.4.3 and suitable statistical methods were applied. The overall prevalence of psychosocial problems amongst adolescent was found to be 41.43%. Most of them had conduct disorder (40.51% males & 35.88% females) followed by depression (30.38% males & 26.72% females). There are significant psychosocial problems amongst the adolescents. So, enough emphasis should be given to this component of adolescent health and thus it is recommended that a holistic approach to the underlying causes of psychosocial problems of adolescents should be undertaken.

Savita M and Bichitra NP (2014); Prevalence of child and adolescent psychiatric disorders in India: a systematic review and meta-analysis. This is the first meta-analysis determining the epidemiology of child and adolescent psychiatric disorders in India. It has been found that the reporting systems of psychiatric disorders in children are inadequate. Case definition and recognition of disorders varies across states or has variable interpretations; and above all the cultural components of what constitutes a disorder remain an important issue. Though it has been suggested that meta-analysis should be carried out once in ten years, there is no meta-analytic study for childhood and adolescent psychiatric disorder so far. This piece of work is the first attempt in this area in India representing a prevalence of 6.4% in community samples and 23.33% in school samples. The need for methodologically sound epidemiological studies for children and adolescent in India is highlighted.

Mumthas M, Muhusina M (2014); A study to assess the psychosocial problems of adolescents at higher secondary level. In this study near about 600 students participated that after analysis of data revealed that adolescents at higher secondary level face more problems from educational and emotional aspects of their life. The study has shown that anger, hot temperedness, academic underachievement and strict rules at secondary and senior secondary level are highest in occurrence.

Kumar D, Abdur R, Arunavo B, Kishor (2014); Stress and Anger of Rural and Urban Adolescents. The purpose of this study was to investigate the relationship between stress and

anger of rural and urban adolescents of Chittagong district in Bangladesh. The sample of the study consisted of 120 respondents of whom 60 were male (30 rural and 30 urban) and 60 were female (30 rural and 30 urban). Their age levels were 13 - 19. They were selected purposively from different areas of Chittagong district in Bangladesh. Bengali version of Life Stress Scale (Fahim, 2001) was used to measure life stress and Bengali version of Adolescents Anger Rating Scale (AARS) (Islam & Chowdhury, 2011) was used to measure adolescents' anger. The obtained data were analyzed by using descriptive statistics, t-test and Pearson product moment correlation. Results revealed that the stress of urban adolescents was greater than rural; the anger of urban adolescents was more than the rural; the stress of female adolescents was more than the male and the anger of female adolescents was more than male. Results also showed that adolescents' stress was positively correlated ($r = .86, p < .01$) with their anger.

Sharma A, Gupta SK, Luthra M and Mishra P (2014); Psychosocial Problems of Adolescents: Influence of Age, Sex & area of residence. The adolescence or the second decade of life (10-19 years) is a crucial decade of life. It is the period demanding significant adjustment to the physical and social changes which distinguish childhood behavior from adult behavior. During this transition between childhood to adulthood rapid demand for new social roles takes place. The adolescents, due to these changes often face a number of crises and dilemmas. If adequate care and attention is not given adolescents are prone to develop various psychosocial problems with long standing impact. The objective of this study was to study the prevalence of psychosocial problems among adolescents in urban and rural areas. Materials & Hence in this case a sample size of 400 adolescents was calculated and 200 adolescents each from rural and urban areas were interviewed with the help of predesigned questionnaire. The overall prevalence of psychosocial problem in the present study was found to be 40.5% with 34.5% in rural area & 46.5% in urban area. Among males it was found to be 48.1% and 26.5% among females. Psychosocial health status of male adolescents was poorer as compared to females with no difference with respect to area of residence. Average problem per adolescent was highest among late adolescents hence there is an immense need of timely intervention to preserve the psychosocial health of this apparently healthy group.

Mohammadi M R, Arman S, Dastjerdi J K et al (2013); A study on Psychological Problems in Iranian Adolescents: Application of the Self Report Form of Strengths and Difficulties Questionnaire. In this study, the highest prevalence of psychological problems in the five provinces was related to conduct problems, and the lowest prevalence was related to social problems. It was determined that girls have more emotional problems than boys. Also, no significant difference was found in the psychological problems of 12 to 14 and 15 to 17 year old adolescents or between middle and high school graduates. In the current study, the prevalence of psychological problems in adolescents in the urban population in Fars province was higher than expected.

Ramaswamy C and Venkatesh K (2012); A study on assessment of adolescent problems in rural and urban areas of mysore. This study assess the adolescent problems among rural and urban adolescents in and around mysore city. A total of 631 teenagers of different age groups

from 11-19 years were randomly selected. They were administered problem checklist developed by Joshi and Pandey, which measures the problem of adolescents in 11 years- health and physical development, finance, living conditions and employment, social and recreational activities courtship sex and marriage psycho social relations, personal moral relations etc. The results of the said study revealed that adolescents living in rural areas were having more problems as compared to those of same age group persons living in the urban areas. Gender wise comparison revealed that males have more problem in finance, living condition, employment, personal, psychosocial, recreational, home, religion as compared to females. The adolescents living in rural area have more problems in psychosocial vocational, recreational, moral and religion areas as compared to other groups of the study.

Manmeet K S, GurpreetS, Goel S (2012); Psycho-socio demographic correlates of school problems in adolescent males in Amritsar district of Punjab. The objective of this study was to assess prevalence of school problems in male adolescents and to study role of psycho-socio-demographic factors. Here in this study 500 adolescents were interviewed using pretested, structured, Questionnaire to elicit the information about problems faced by them in school, academic performance, role of friends and family in studies, association with psychological problems, substance abuse and sexual activity. The predictors of school problems in male adolescents were education status of parents, family/household income and a large family . The academic problems were associated with depression, substance abuse and disturbed family environment.

Gurpreet S C, Manmeet K S; (2011); Factors Contributing to Psycho-Social Ill-Health in Male Adolescents. The objective of this study was to study the prevalence of psychosocial problems in male adolescents and find out various factors contributing to psycho-social ill health. In this study five hundred adolescents were interviewed using a pre-tested structured questionnaire to elicit the information about the psychosocial problems including depression, suicidal thoughts and suicidal attempts. Association of academic performance, family problems, psychological problems and substance abuse was also included. The results have depicted that more than one third (39.6%) adolescents were having psychological problems. These problems were significantly higher in middle adolescence (14-16 years), large extended families (> 8 members) and lower socioeconomic status. Residence had no significant relation to psychological problems in the adolescents. On correlation, these adolescents with psychological problems were having significantly more academic problems, family disputes, domestic violence, lesser number of close friends and greater substance abuse. The researchers at the end of this study considered that male adolescents from large families with lesser education and lower income had higher prevalence of psychosocial problems, it is essential for health care planners to design comprehensive family and health education programs for the adolescents. The family support, teacher student rapport and peer group communication should be strengthened to counteract unsafe behaviors in the adolescents.

Firdous W, Paul M A, Kumar P et al (2011); A study on Self-esteem and Psychosocial problems among Kashmiri Youth. The findings indicated significant negative correlation

between self-esteem and problem areas. No significant difference was found in self-esteem in males and females in urban and rural group. However significant difference was found between rural and urban adolescents in family, school, social and personal problems. Male and female groups differed significantly only in personal problems. Significant difference was found among all the three levels of self-esteem and their personal and family problems. The Overall findings suggest that rural adolescents suffer more problems than urban adolescents and thus highlight the need of community based mental health care.

Helena RS, Olga A. Tatyana I et al (2010); Siberian Child and Adolescent Mental Health: Prevalence Estimates and Psychosocial Factors. The aim of this study was to estimate the prevalence of child and adolescent mental health problems in Siberia and to investigate the effects of psychosocial factors. A cross-sectional study with the stratified randomized sample of schoolchildren provided prevalence estimates. Second study involved 1,382 adolescent self-reports and 1,864 parent reports of three through 17 year old children. Prevalence of psychiatric disorder in Siberian children is around 15–20%; emotional and behavioral disorders are the two most common categories. Psychosocial factors explained around 15% of internalizing problems, and up to 30% of externalizing problems. Harsh parenting was a risk factor; intact family, parent's education, family cohesion and safe neighborhood contributed to the lower level of problems. The rate of child psychiatric problems in Siberia is higher than in the developed countries; the type of the problems is similar to other countries. Life style factors were more powerful predictors than measures of socio-economic status. Prevention should be aimed at identified risk factors and disadvantaged children.

Seema C, Mishra CP, Shukla KP (2010); A study on psychosocial behavior of adolescent girls in rural area of Varanasi. In this study Two hundred and seventy adolescent girls between 10-19 years of age responded to questionnaire. The Relationship of study subjects has been cordial in majority of cases while some experienced problems with siblings. Majority (80.00%) of them shared their heartfelt feelings with their mothers. Considerable number of girls experienced anger (46.54%) and unhappiness (68.89%) when reprimanded; half of them resorted to dietary restriction for the next meal. Majority (89.63%) of subjects become happy on admiration and resorted to no dietary modification. Two out of five girls were in favour of practicing religious fast during adolescence. Psychosocial behavior was not significantly ($p>0.05$) associated with nutritional status of adolescent girls.

Saleema A, Tazeen S A, Amina A and Neesha H (2010); The Influence of Psychosocial Factors on Academic Performance of Adolescents: A Quality Assurance Project. Adolescence is a time of rapid psychological and physiological changes and is associated with anxiety and mental distress. This project looks at the potential of school-based programs to reduce these negative effects of academic performance in both the short- and long-term. This study was conducted in a private school in Karachi, Pakistan between October 1998 and December 2006 on 305 students with low academic performance. Results show that students scoring low grades had a mean of $55 + 2.8$ and post intervention score of $56 + 2.6$. The intervention package significantly created a difference in reducing the number of students receiving low grades. Qualitative analysis showed that study participants had enhanced self-

esteem, confidence levels, positive attitudes towards learning, improved time management and decision-making skills. This suggests that in an academic institution, the presence of a professional support system enhances learning and coping mechanisms. Another outcome of this study is a better understanding of the role that the school health nurse plays within the school: preventative, promotive, and that of a counsellor. Her role is holistic, and thus she must be well-educated in all matters relevant to adolescent health.

Karadag C, Hilal C (2010); Adolescents Living in Orphanages in Ankara: Psychological Symptoms, Level of Physical Activity, and Associated Factors. The study group consisted of 13-16-year-old adolescents (N=166) living in orphanages in Ankara, Turkey. Data were collected cross-sectional in 2008 via questionnaires, including the Brief Symptom Inventory and Kiddo-KINDL Health-Related Quality of Life Questionnaire. Descriptive statistics were used to summarize data, whereas chi-square, ANOVA, Mann-Whitney U, Kruskal-Wallis, and t tests were used to compare groups. Median age of the participants was 16.0 years and 65.7% were male. Female gender, not going to school or work, dissatisfaction with school, contact with the family, chronic disease, chronic medication use, sleep problems, regular tobacco use, chronic disease in the family, and low quality of life score were associated with increased risk (GSI-Global Symptom Index >1 SD) for mental disorders. Physically active adolescents' use of tobacco, alcohol, other substances, and medications, as well as GSI and depression scores were lower and their quality of life scores were higher than those of their less active counterparts. Conclusion: Prevalence of psychological symptoms in adolescents living in orphanages were higher than in the general adolescent population. Physically active adolescents' mental health indices and abstinence behaviors with regard to tobacco, alcohol, and substances were more favorable. Encouraging adolescents to participate in sports and improving sports facilities in orphanages are interventions that can promote mental health.

Dhoundiyal M, Venkatesh R (2009); A cross-sectional study was conducted to get an insight into the psychological world of adolescence and to study the influence of locality and school-going activity on it. The study group comprised of 240 girls in the age group 12-18 years equally representing urban and rural areas. Using two psychological tests, namely Strengths and Difficulty Questionnaire and Health-Related Quality of Life Inventory, the results revealed that two-third of them were in the problematic and borderline category as per SDQ and one-third as per PedsQL.

Ahmad A, Khalique N, Khan Z, Amir A (2007); Prevalence of psychosocial problems among school going male adolescents. It was found that 82.1% of the study population was free from the psychosocial problems studied. Thus the prevalence of the overall psychosocial problems was 17.9% among male adolescents with insignificant urban and rural difference. The most common problem was educational difficulties found in 17.4% of the study population, followed by substance abuse with a prevalence of 13.3% and conduct disorders 9.2%. The prevalence of the psychosocial problems was maximum 25.2% in 14-15 years age group and minimum (10.3%) in the 10-13 years age group. The difference of overall psychosocial problems was found significant. Conduct disorders were also maximum (12.9%) in the 14-15 years age group. Substance abuse was minimum (4.8%) in the 10-13

years age group, followed by 18.7% in the 14-15 years age group and maximum (20.9%) in the 16-19 years age group. The rising trend of substance abuse with age is highly significant.

Ezpeleta L, Keeler G, Erkanti A, et al (2001); Epidemiology of Psychiatric Disability in Childhood and Adolescence. The goal of the study was to ascertain the factor structure and prevalence of psychiatric disability in children and adolescents in relation to demographic variables and diagnosis. A representative sample of 1420 children (9±13 years) from 11 countries in North Carolina was followed for up to 6 years. Children and caretakers were interviewed with the Child and Adolescent Psychiatric Assessment, which generates DSM-IV diagnoses and includes a measure of disability secondary to psychological symptoms. Three broad areas of disability were identified (relating to family, school, and peers). School disabilities were more common in boys than girls, while the reverse was true of family disability. Effects of age were complex, and partially gender-differentiated. Children from minority ethnic groups had a higher overall prevalence of school disabilities, and were more prone than Whites to the disabling effects of disruptive behavior disorders. Anxiety disorders were as likely to result in disability as depressive disorders, and oppositional defiant disorders were more strongly associated with disability in some areas than was conduct disorder. The areas where disability is manifested are different depending on race, gender, age, and the type of disorder suffered.

Birmaher B, Royan ND, Williamson DA, et al (1996); Childhood and adolescent depression. This study was started in order to qualitatively review the literature of the past decade covering the epidemiology, clinical characteristics, natural course, biology, and other correlates of early-onset major depressive disorder (MDD) and dysthymic disorder (DD)-psychological problems in children and adolescents. Here in this study a computerized search for articles published during the past 10 years was made and selected studies are presented. As we know that early-onset MDD and DD are frequent, recurrent, and familial disorders that tend to continue into adulthood, and they are frequently accompanied by other psychiatric disorders. These disorders are usually associated with poor psycho-social and academic outcome and increased risk for substance abuse, bipolar disorder, and suicide. In addition, DD increases the risk for MDD. This study has revealed long ago that there is a secular increase in the prevalence of MDD, and it appears that MDD is occurring at an earlier age in successive cohorts. Several genetic, familial, demographic, psychosocial, cognitive, and biological correlates of onset and course of early-onset depression have been identified. Few studies, however, have examined the combined effects of these correlates. Considerable advances have been made in our knowledge of early-onset depression. Nevertheless, further research is needed in understanding the pathogenesis of childhood mood disorders. Toward this end, studies aimed at elucidating mechanisms and interrelationships among the different domains of risk factors are needed.

Murphy JM, Reedle J et al (1992); Screening for Psychosocial dysfunction in inner-city children. This study followed up on 201 pediatricians and family practitioners who had requested information about the Pediatric Symptom Checklist (PSC), a parent-completed questionnaire which screens for psychosocial dysfunction in school-aged children. The

physicians were sent a postcard survey asking whether they had used the PSC in their practices. Of the 157 (78%) who responded to the postcard survey, 36 (23%) reported that they had used the PSC. On a follow-up questionnaire, all of these physicians rated the PSC as useful, and nearly 80% reported that it led to increased case-finding and/or referrals. Ninety-six percent stated that they will continue to use the PSC; more than half of them routinely or frequently. The findings indicate a widespread interest in psychosocial screening, and suggest that additional educational efforts may be necessary to support the acceptance of the PSC in pediatric practice.

Jellinek MS, Murphy JM, Burns BJ (1990s); Brief Psychological screening in inpatient and outpatient pediatric practice; Screening for Psycho-social Dysfunction in Pediatric Inpatients; Screening pediatric inpatients for psychosocial dysfunction offers physicians an opportunity to identify emotional and behavioral problems that might otherwise go unrecognized. In this study, the Pediatric Symptom Checklist (PSC), a brief, parent-completed questionnaire, which has been validated in a variety of outpatient settings, was used to screen 98 pediatric inpatients. Results indicated that the PSC can be easily administered in a busy inpatient setting and is well-tolerated by both house staff and patients' parents as a routine part of the admissions process. The percentage of children who screened positive with the PSC in this inpatient setting was similar to the percentages generated by using the PSC in outpatient settings. Routine use of the PSC in inpatient settings serves to heighten house staff awareness of psychosocial concerns and facilitate parent-physician discussion of pediatric mental health issues.

Walker W O, Lagrone R G, (1989); Psychosocial Screening in Pediatric Practice: Identifying High-Risk Children. The purpose of this study was to evaluate the effectiveness of the Pediatric Symptom Checklist (PSC) as a psychosocial screening instrument. Using the PSC, the researchers screened 212 patients, ages 6-12 years, at a military outpatient pediatric clinic. Twenty-one children with scores in the "high-risk" range were randomly selected and matched with children scoring in the normal, "not-high-risk" range. Two trained interviewers, blind to individual PSC scores, independently interviewed and rated each subject's level of psychosocial functioning on the Children's Global Assessment Scale (CGAS). The Child Behavior Checklist (CBCL), a standardized psychosocial measure, was also completed by each subject's mother. PSC scores were compared to the CGAS and CBCL scores in terms of sensitivity and specificity. Additional analyses compared data from the study sample with that of previous studies. Results suggest that the PSC is a valid pediatric psychosocial screening instrument for multiethnic patient populations.

Kalaiyarasan M, Daniel M et al; Mental health among adolescence. The study has revealed that there is more influence of good peer relation and healthy school environment on mental health of adolescents. Parent Child Relation, Peer Relation and School Environment towards Mental Health is more in girls than boys. Mental health has not any relationship with psychotics and neuroticism dimensions of personalities. There is no significant relationship of mental health with moral judgment, intelligence and different dimensions of personality for the groups of adolescents having low mental health. There is a negative relationship between

the education and mental health of the participant. Psycho-social intervention had helped to enhance the mental health of the adolescents and consequently their improvement in academic. Supports that Life Skills Training increase students' Self –esteem, mental health and Assertiveness. Mental health programs are wide spread among Indian student. Strength and difficulties questionnaire could also be used in a primary care setting to screen adolescence for mental health. Relationships between Religious/Spiritual and mental health were generally stronger or more unique for males and older adolescents than for females and younger adolescents. Mental health education promotes the school adolescence mental health. There is more adolescent boys had poor 44.6 percent or average 41.3 percent mental health. About half of adolescent girls had average mental health. There is a highly significant positive correlation among self-confidence, mental health and emotional intelligence among adolescence. School life skill education program had significantly better self-esteem perceived adequate, coping better adjustment generally specifically with teachers in school, and pro-social behavior. Majority of the respondents scored low on anxiety and scored high on depression, stress. Among the tribes adolescence found to be that student were shy and withdrawn. Whereas urban student were much open and warm.

CHAPTER: III

RESEARCH METHODOLOGY

Source of Data;

Data means the information collected by me on Youth self-report from the adolescents of selected rural and urban secondary and senior secondary schools of the Kashmir. The data was collected from the rural schools of district Baramulla sub division Tangmarg and urban schools of district Srinagar. The selected schools offered formal education from 1st to 12th standards and cater coeducation with approximately 600 students and run under private and government management.

Research Design;

Keeping in view, the problem statement, the objectives and hypothesis of the research it was seen that the best research design for this study was descriptive research design. It is this design that helped us to know the association between research variables.

Population of the study;

The population of this study refers to the adolescents who were studying in the rural and urban schools of Kashmir. The selected population was divided into two groups. One group was hailing from the rural schools that belonged to the subdivision Tangmarg of the district baramulla and the other group belonged to the urban schools of Srinagar i.e. soura. All the students were in the age group of 12-19 years. Thus the target population were the adolescents studying in the schools of rural and urban communities.

Sample of the study;

In this study, the sample size was fixed to be 200 adolescents. Out of these 200 samples, 100 samples were taken from rural areas and 100 from the urban areas. Moreover the sample was further divided into two sets in the rural and urban areas on the basis of gender. So, the number of boy adolescents in the sample was 50 from rural area and the number of girl adolescents from the rural area was also 50. In the same manner the sample was distributed as 50 female adolescents and 50 male adolescents from the urban areas making a total number of 200.

Sampling procedure;

The samples of the study were selected by a Non-probability sampling technique namely convenient sampling technique. The samples were selected by this technique as there were no abundant students coming to school because of the prevailing conditions(curfew and hartals) in the valley and when conditions were restoring to near normal the government of Jammu and Kashmir declared winter vacations. Thus at the time of data collection whosoever in the age group of 12-19 years were present were taken as samples after established criteria as mentioned earlier.

Research setting;

The study was conducted in the selected rural and urban schools of Kashmir valley. The selected schools run classes from 1st to 12th catering co-education and are under the

government and private managements. The study was conducted in following schools in the district baramulla viz Govt. hr. sec. school, chandilora Tangmarg.

Govt. hr. sec. school, lalpora Kunzer.

Govt. model high school, Dhobiwan Kunzer.

Iqbal memorial institute, Kunzer.

The schools in the urban area from where the samples were collected are

Govt. hr. sec. school, soura Srinagar.

Govt. high school, Umerhair Srinagar.

Galaxy Public Secondary school, 90 feet road soura Srinagar.

Selected variables;

In this study two types of variables were selected. These variables are briefly explained as under-

Criterion Variable:

In this study it refers to the level of Psycho-social problems faced by adolescents in the rural and urban areas as depicted by the Psycho-social problem score.

Predictor Variables:

In this study it refers to the selected baseline characteristics in the part I of the tool reflecting participants age, gender, type of family, family income and birth order.

Inclusion criteria for Sampling;

Those adolescents who were present at the time of study in the selected rural and urban schools were included in the study. Also those boys and girls who were willing to be part of this research project and thus gave their consent to be so were included in the preparation of this thesis.

Exclusion criteria for Sampling;

Those students who were not present at the time of data collection were obviously excluded from the research. Also those who were not interested to be a part of this project were also excluded from this work.

Tool or Instrument used for Data Collection;

The tool that was used for this research was earlier developed by Thomas M Achenbach and C.S Edelbrock. The tool that they have developed is known as Youth Self Report. This youth Self Report is divided in 2 sections viz part first contains the biographic data and part 2nd of the instrument consists of a self-reported scale of Psycho-social problems. The biographic data has different components like age, gender, type of family, family income and the birth order of the respondent. The part II of the tool consists of 70 negatively stated statements each having three options as never, sometimes, and often. While giving score to the adolescents self-reported psycho-social scale, the option of Never was given a score of zero, Sometimes was given a score of one and Often was scored as two. Thus the total number of score that this scale had, was one hundred and forty [140]. While analyzing the results the score of the scale was arbitrarily classified as follows:

01-35; An adolescent having score in this range was considered to be well adjusted and having no deviation.

36-70; An adolescent having score in this range was considered to be having mild Psycho-social Problem.

71-105; An adolescent having score in this range was considered to be having moderate Psycho-social Problem.

106-140; An adolescent having score in this range was considered to be having severe Psycho-social Problem.

Data Collection Method;

The researcher at first approached the program counsellor at IGNOU study center 1209 and submitted his research proposal. The counsellor after examining the research proposal accepted it and gave nod to carry out the same research in the valley of Kashmir. Permission was taken from Program coordinator by esteemed counsellor for the said purpose. After this required number of youth self-report scale were printed and researcher was ready with the required instrument to collect the data from the adolescents in rural and urban area.

The researcher approached to the heads of few secondary and senior secondary schools in the rural area, as named earlier in the operational definitions. The school in-charges of the mentioned schools gave permission for data collection. In the procedure of data collection I was helped by my few friends. Here in the selected rural schools data was collected in such a way that from each class [8th to 12th] equal number of adolescent boys and girls were selected as samples to make a total of 100 samples from rural area. Data was collected from 15th of November 2016 from 11am to 3pm. After completion of data collection in rural area, I switched to collect the data in urban areas i.e. Srinagar city.

Here in the urban areas some of the school principals refused to give permission for the data collection for said research project, so it was difficult affair to handle and tackle. Later on I asked for help to my fellow colleague who by profession is a clinical Nurse namely Ms. Abida Jan and knew a few school heads in the government and private sector of the city. She got the prior permission for data collection from the principals of secondary and senior secondary schools and later on helped me in the whole process in urban area as well. The data was collected in the urban area in the same fashion as that of the rural area so that every adolescent from every class got its share in the sample to make total number as 100. The data was collected from 5th of December 2016 to 25th of December 2016 from 11am to 3:30pm.

CHAPTER: IV

RESULT, ANALYSIS & DISCUSSION

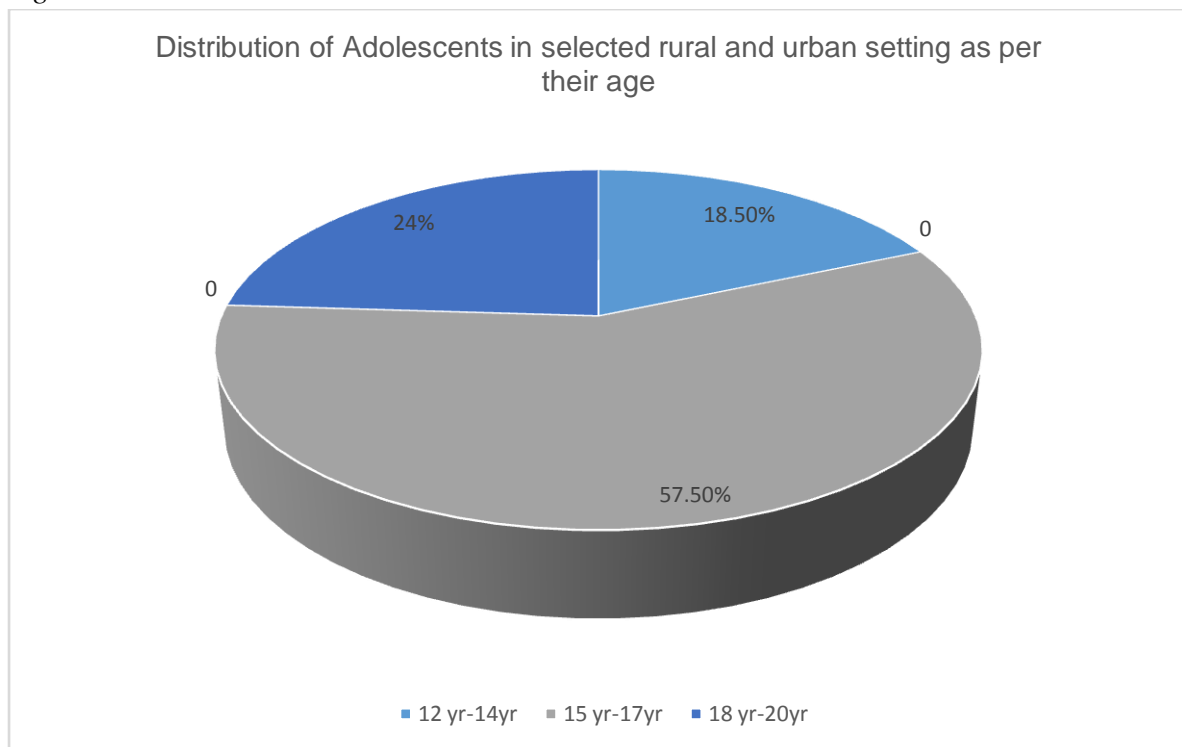
Descriptive statistics

Table 1.0 Table showing Frequency and Percentage distribution of adolescents as per their age in selected urban and rural settings.

N=200

Age in years	No. of adolescents	Percentage
12 yr-14yr	37	18.5%
15 yr-17yr	115	57.5%
18 yr-20yr	48	24%

Figure 1.0



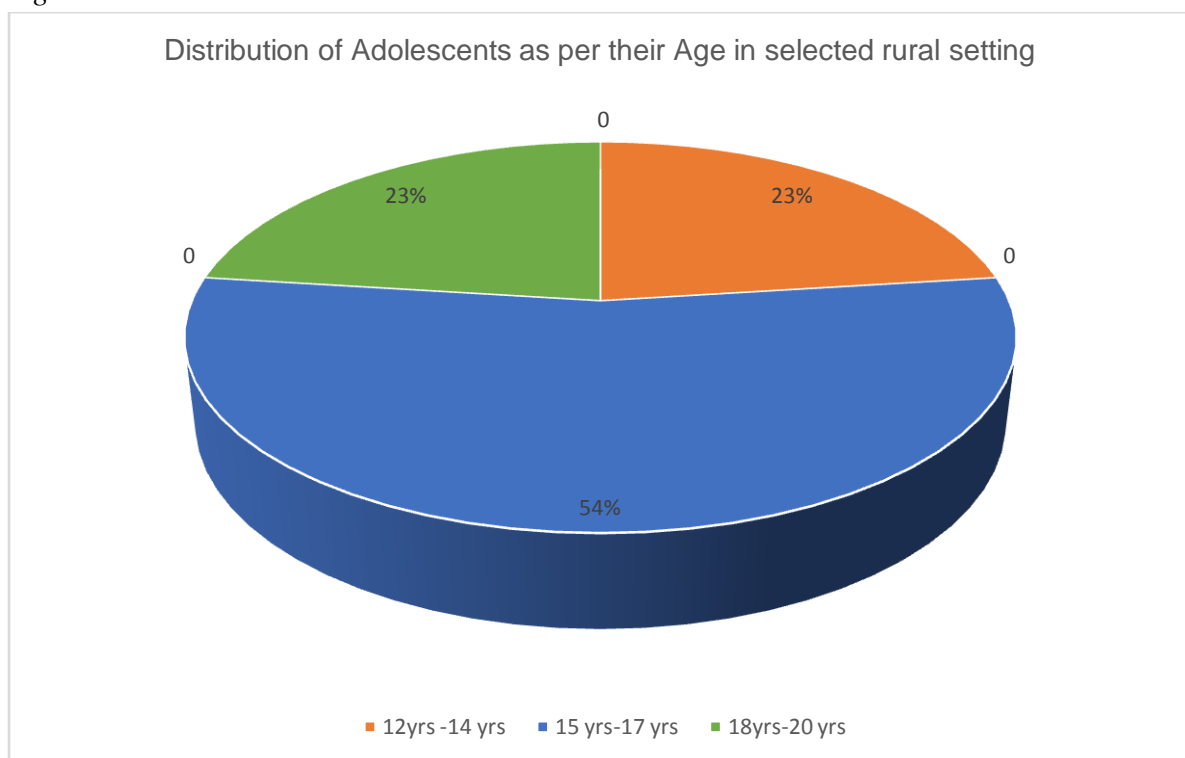
This pie diagram depicts that highest number of adolescents i.e 57.50% belonged to age group of 15-17 years of age, 24% of adolescents belonged to age group of 18-20 years while as 18.5% adolescent study population belonged to 12-14 years of age.

Table 1.1 Table showing Frequency and Percentage distribution of adolescents as per their age in selected rural setting.

Nr=100

Age in years	No. of adolescents	Percentage
12 yr-14yr	23	23%
15 yr-17yr	54	54%
18 yr-20yr	23	23%

Figure 1.1

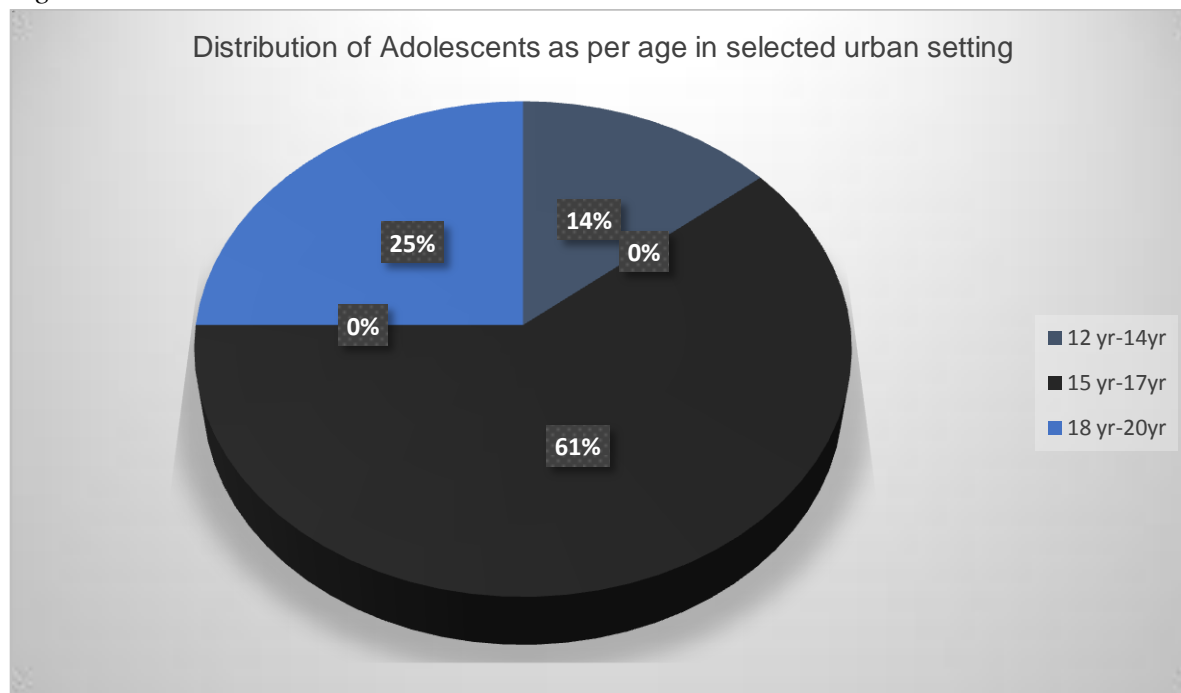


This pie diagram depicts that in selected rural schools 35% of the adolescents were in the age group of 12-14 years, 42% were in the age group of 15-17 years and 23% were in the age group of 18-20 years.

Table 1.2 Table showing Frequency and Percentage distribution of adolescents as per their age in selected urban setting. *Nu=100*

Age in years	No. of adolescents	Percentage
12 yr-14yr	14	14%
15 yr-17yr	61	61%
18 yr-20yr	25	25%

Figure 1.2



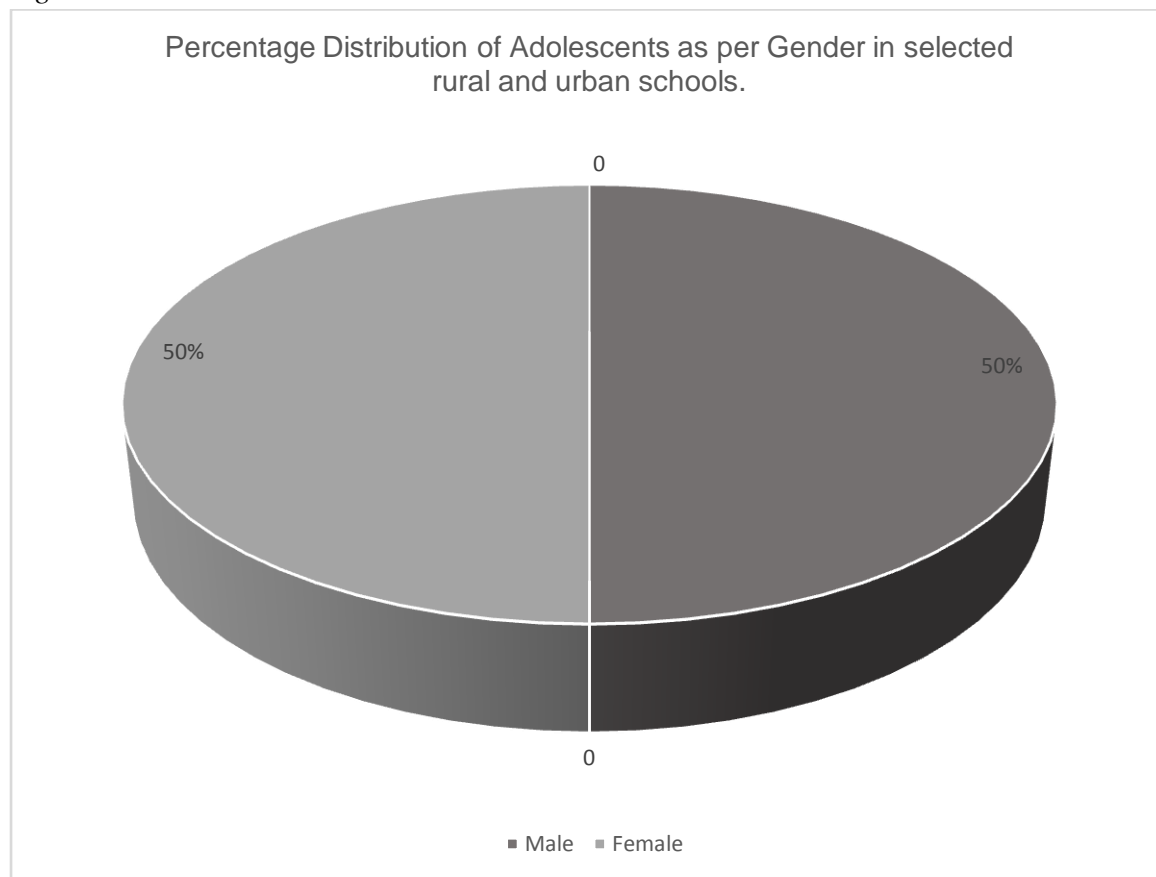
This pie diagram depicts that 14% of the adolescents were in the age group of 12 -14 years, 61% Were in the age group of 15-17 years of age and 25% of adolescents belong to age group of 18-20 years of age.

Table 2.0 Table showing Frequency and Percentage distribution of adolescents as per Gender in selected urban and rural setting.

N=200

Gender	No. of adolescents	Percentage
Male	100	50%
Female	100	50%

Figure 2.0



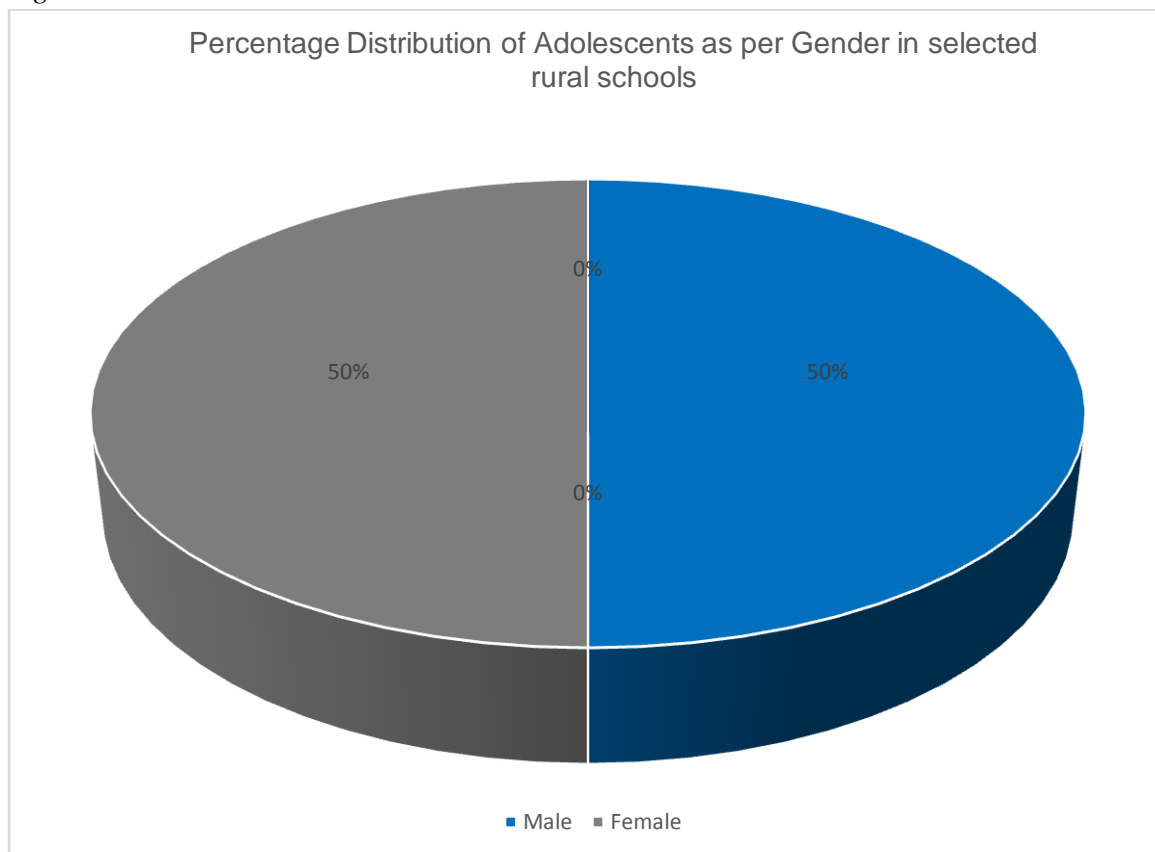
This diagram represents that both male and female Adolescents participated in this study equally in selected rural and urban schools and their percentage is 50% each.

Table 2.1 Table showing Frequency and Percentage distribution of adolescents as per Gender in selected rural setting.

Nr=100

Gender	No. of adolescents	Percentage
Male	50	50%
Female	50	50%

Figure 2.1



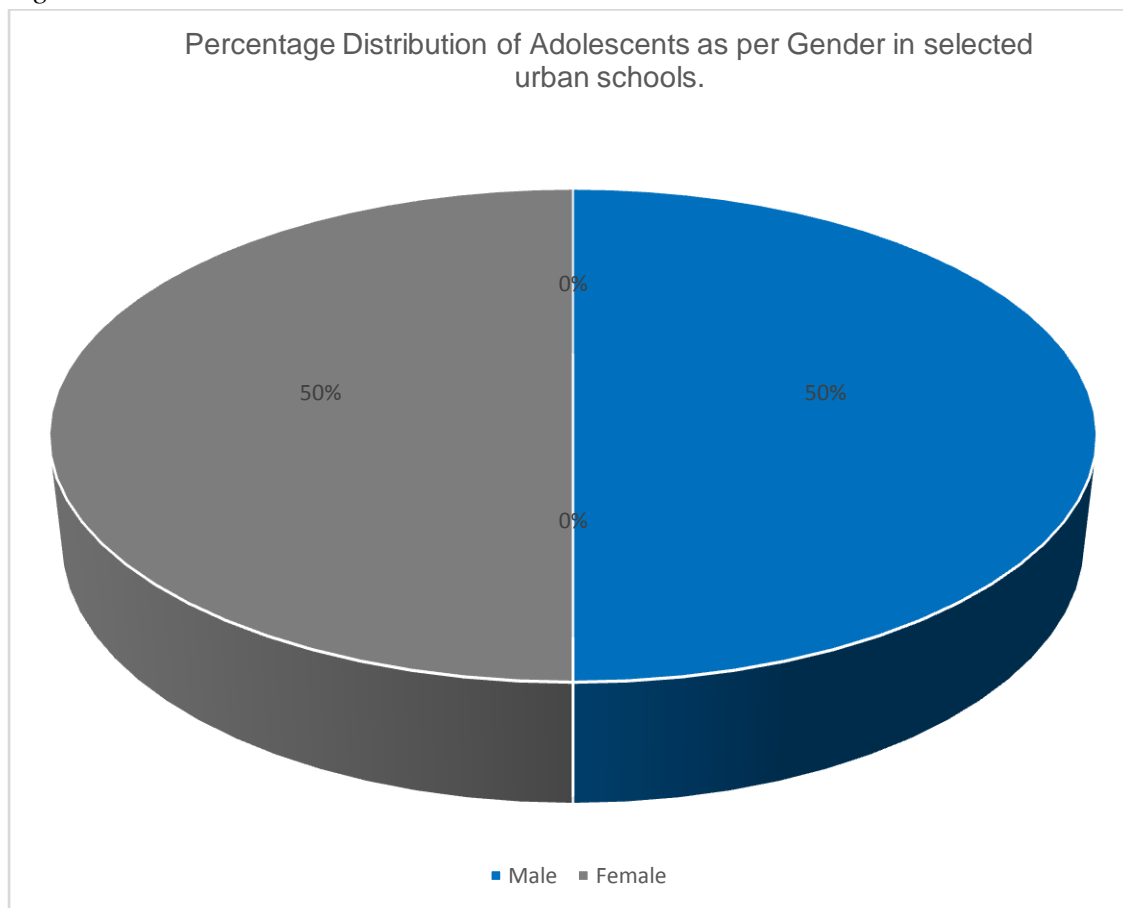
This pie diagram represents that 50% of male adolescents and 50% female adolescents participated in the study from selected rural schools.

Table 2.2 Table showing Frequency and Percentage distribution of adolescents as per Gender in selected urban setting.

Nu=100

Gender	No. of adolescents	Percentage
Male	50	50%
Female	50	50%

Figure 2.2



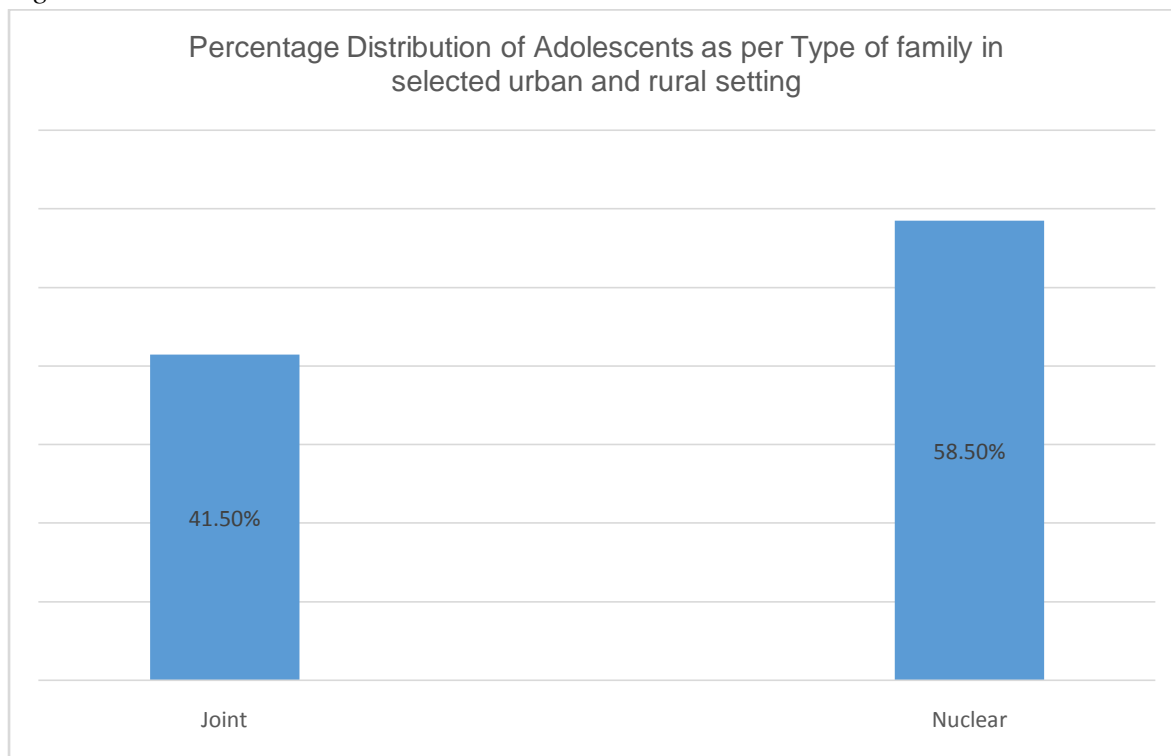
This pie diagram represents that 50% of male adolescents and 50% female adolescents participated in the study from selected urban schools.

Table 3.0 Table showing Frequency and Percentage distribution of adolescents as per their Type of Family in selected urban and rural setting.

N=200

Type of Family	No. of adolescents living in	percentage
Joint	83	41.5%
Nuclear	117	58.5%

Figure 3.0



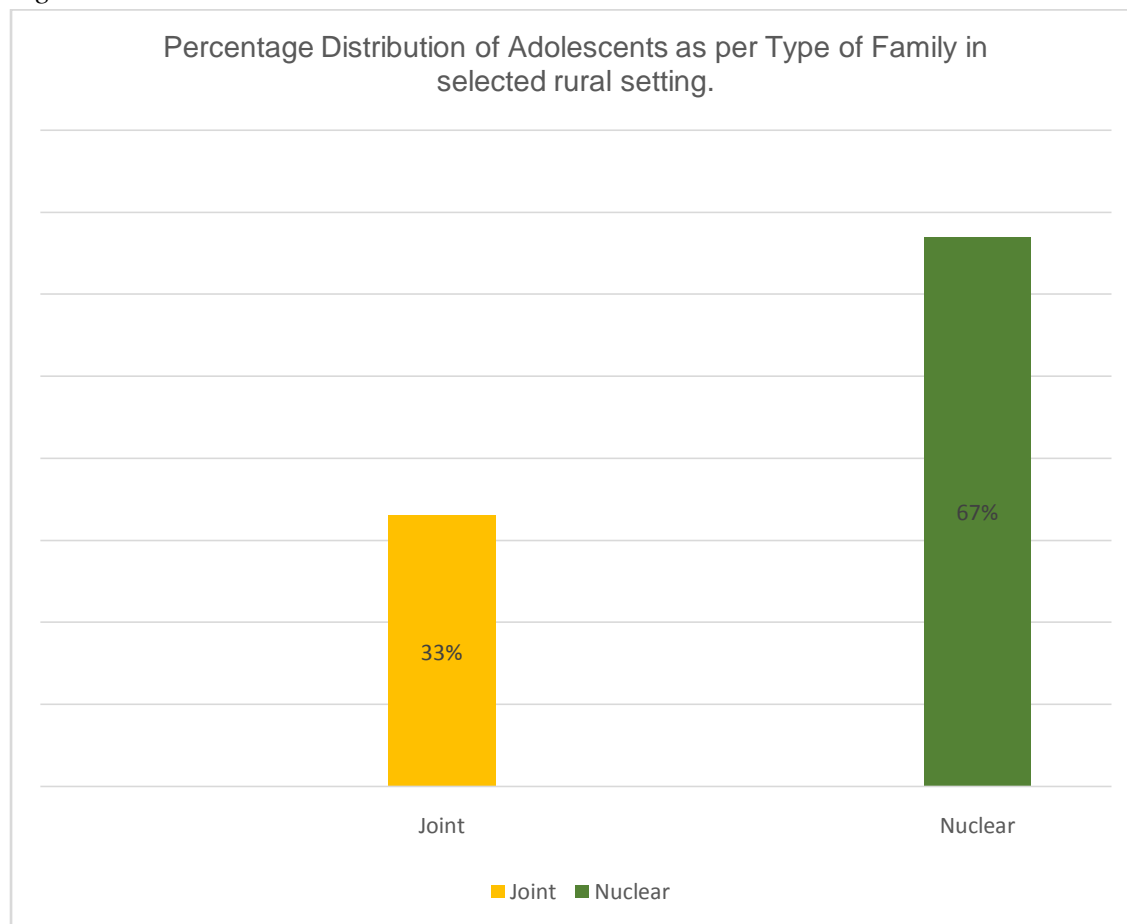
This bar diagram shows that only 41.50% of adolescents were living in Joint families and 58.50% of them were living in Nuclear families in the selected rural and urban setting.

Table 3.1 Table showing Frequency and Percentage distribution of adolescents as per their Type of Family in selected rural setting.

Nr=100

Type of Family	No. of adolescents living in	Percentage
Joint	33	33%
Nuclear	67	67%

Figure 3.1



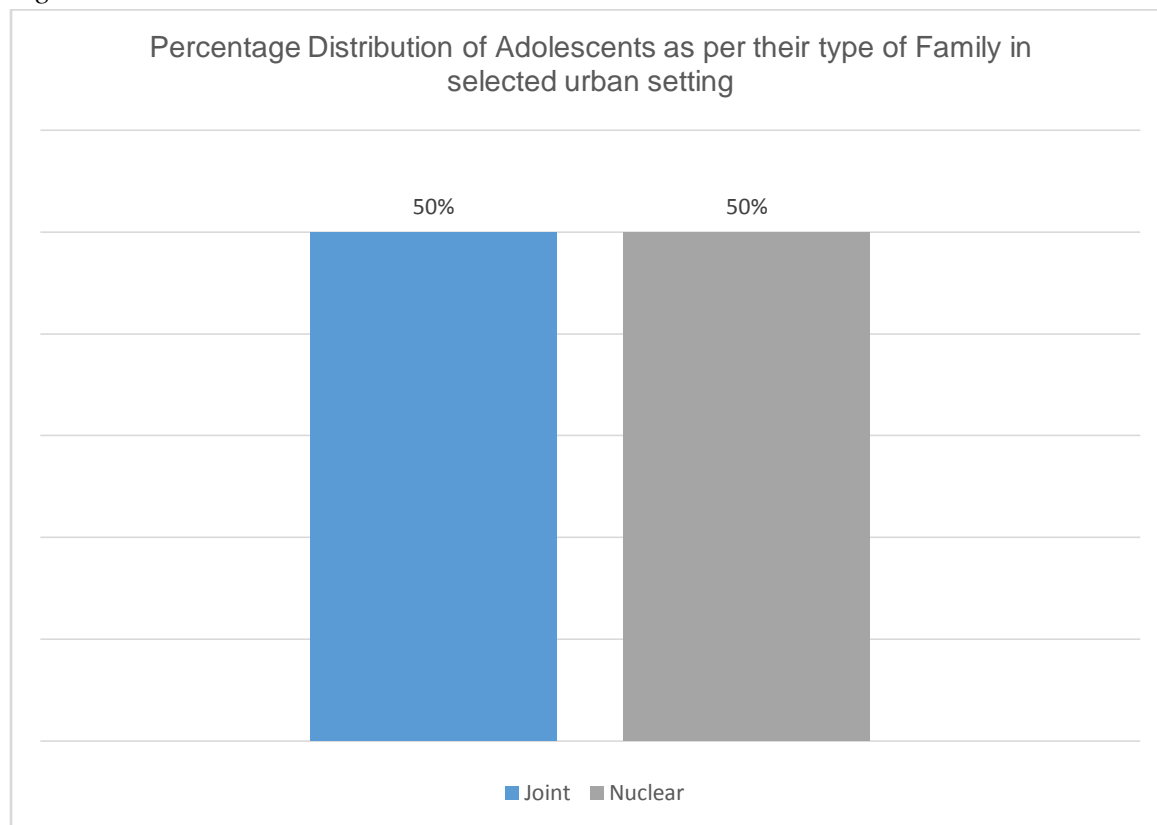
This bar diagram shows that only 33% of rural adolescents were living in Joint families and 67% of them were living in Nuclear families in the selected rural setting.

Table 3.2 Table showing Frequency and Percentage distribution of adolescents as per their Type of Family in selected urban setting.

Nu=100

Type of Family	No. of adolescents living in	Percentage
Joint	50	50%
Nuclear	50	50%

Figure 3.2



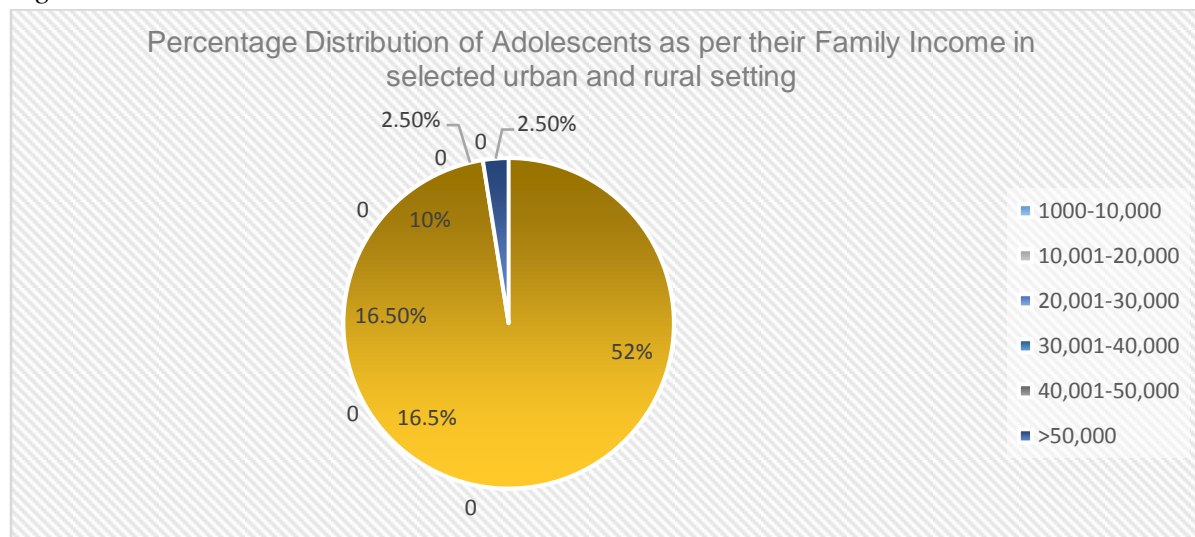
This bar diagram shows that 50% of urban adolescents were living in Joint families and rest of the 50% were living in Nuclear families in the selected urban setting.

Table 4.0 Table showing Frequency and Percentage distribution of adolescents as per their Family Income in selected urban and rural setting.

N=200

Family Income per month	Frequency	Percentage
1000-10,000	104	52 %
10,001-20,000	33	16.5 %
20,001-30,000	33	16.5 %
30,001-40,000	20	10 %
40,001-50,000	05	2.5 %
>50,000	05	2.5 %

Figure 4.0



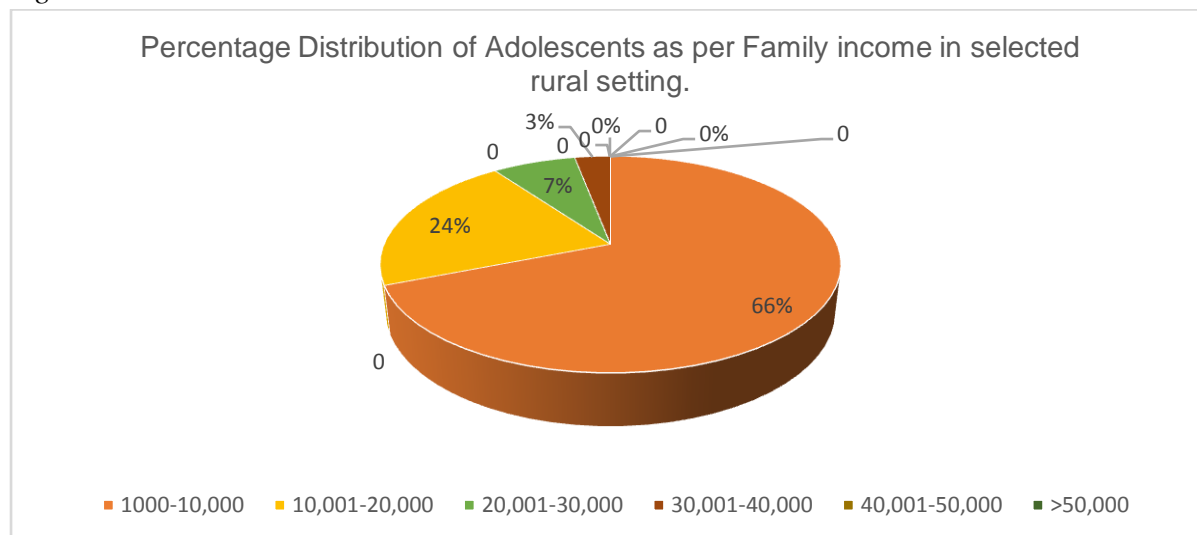
This diagram shows that majority of adolescents i.e. 52% were hailing from the families whose monthly income was in between 1000-10,000 rupees and there were only 2.5% adolescents whose income exceeded Rs. 50,000 per month. Here 16.5% had income in between 10,001- 20,000 and 16.5% had in between 20,001-30,000 while as only 10% had income in between 30,001-40,000 and 2.5% had family income in between 40,001- 50,000.

Table 4.1 Table showing Frequency and Percentage distribution of adolescents as per their Family Income in selected rural setting.

Nr=100

Family Income per month	Frequency	percentage
1000-10,000	66	66%
10,001-20,000	24	24%
20,001-30,000	07	07%
30,001-40,000	03	03%
40,001-50,000	0	0%
>50,000	0	0%

Figure 4.1



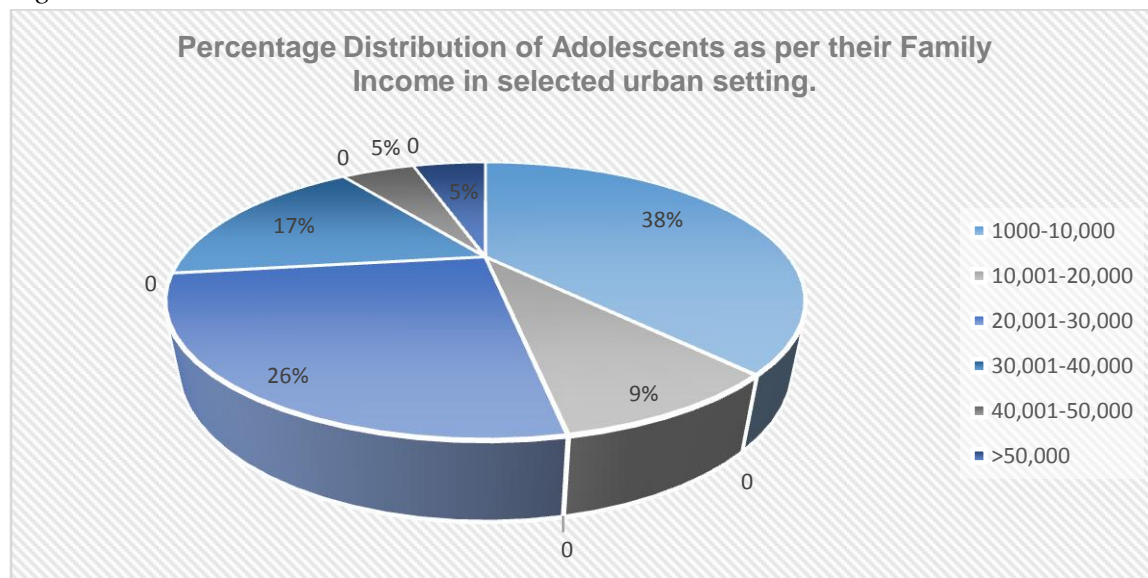
This diagram shows that majority of adolescents i.e. 69% were hailing from the families whose monthly income was in between 1000-10,000 rupees and there were no adolescents whose income exceeded Rs. 50,000 per month. Here 20% had income in between 10,001-20,000 and 7% had in between 20,001-30,000 while as only 4% had income in between 30,001-40,000.

Table 4.2 Table showing Frequency and Percentage distribution of adolescents as per their Family Income in selected urban setting.

Nu=100

Family Income per month	Frequency	Percentage
1000-10,000	38	38 %
10,001-20,000	09	09 %
20,001-30,000	26	26 %
30,001-40,000	17	17 %
40,001-50,000	05	05 %
>50,000	05	05 %

Figure 4.2



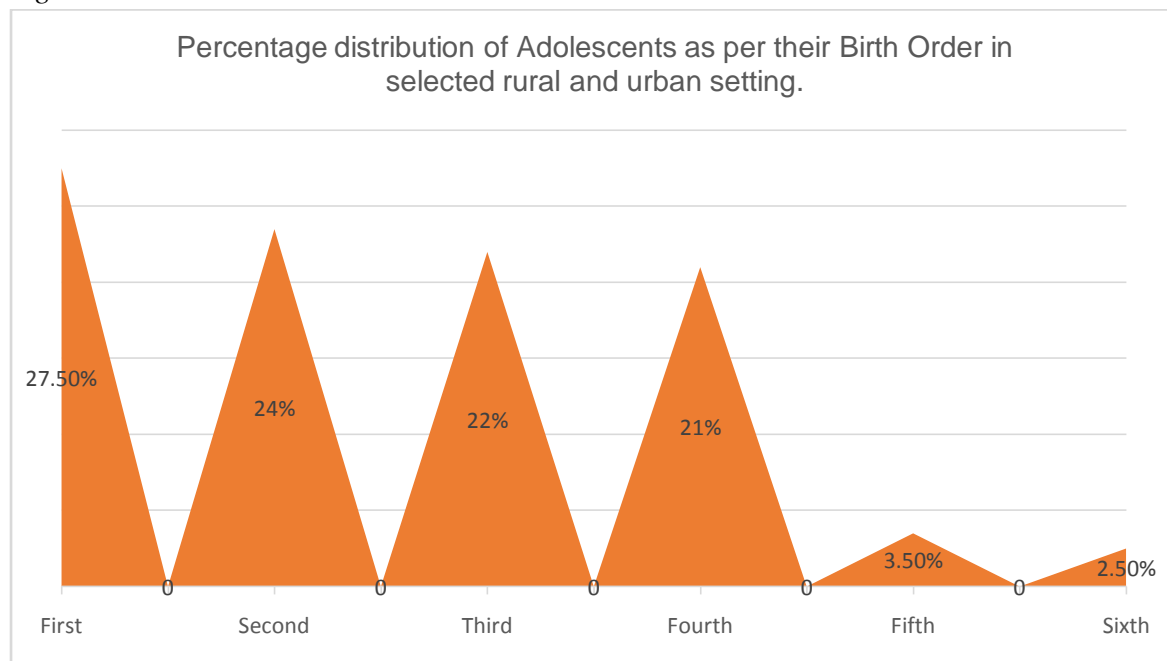
This diagram shows that majority of adolescents i.e. 38% were hailing from the families whose monthly income was in between 1000-10,000 rupees and there were only 5% adolescents whose income exceeded Rs. 50,000 per month. Here 9% had income in between 10,001- 20,000 and 26% had in between 20,001-30,000 while as only 17% had income in between 30,001-40,000 and 5% in between 40,001-50,000.

Table 5.0 Table showing Frequency and Percentage distribution of adolescents as per their Birth Order in selected urban and rural setting.

N=200

Birth Order	Frequency	Percentage
First	55	27.5 %
Second	47	23.5 %
Third	44	22 %
Fourth	42	21 %
Fifth	07	3.5 %
Sixth	05	2.5 %

Figure 5.0



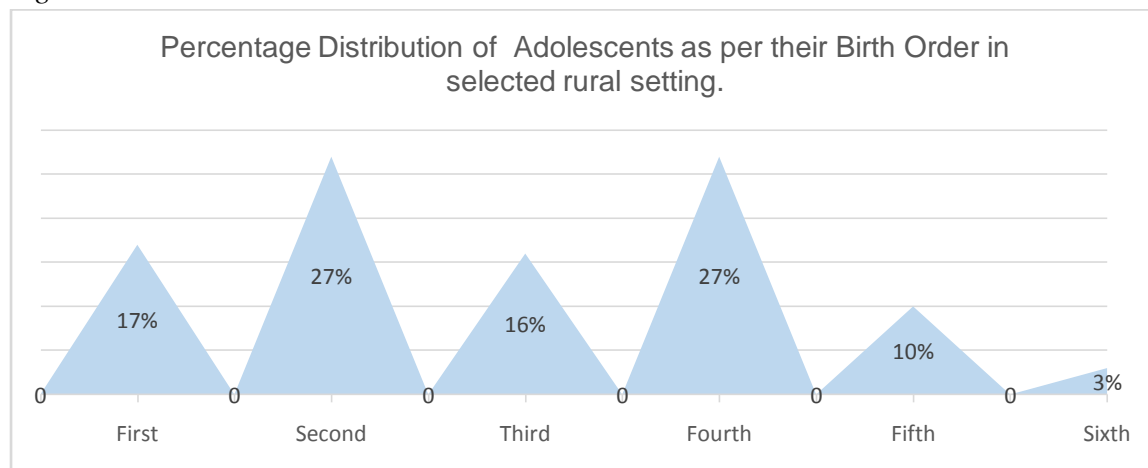
This area diagram shows that 27.50% of adolescents in rural and urban setting were having their birth order as first, 23.50% had second, 22% had third, 21% had fourth, 3.5% had fifth, and only 2.5% had sixth as their birth order.

Table 5.1 Table showing Frequency and Percentage distribution of adolescents as per their Family Income in selected rural setting.

Nr=100

Birth Order	Frequency	Percentage
First	17	17%
Second	27	27%
Third	16	16%
Fourth	27	27%
Fifth	10	10%
Sixth	03	03%

Figure 5.1



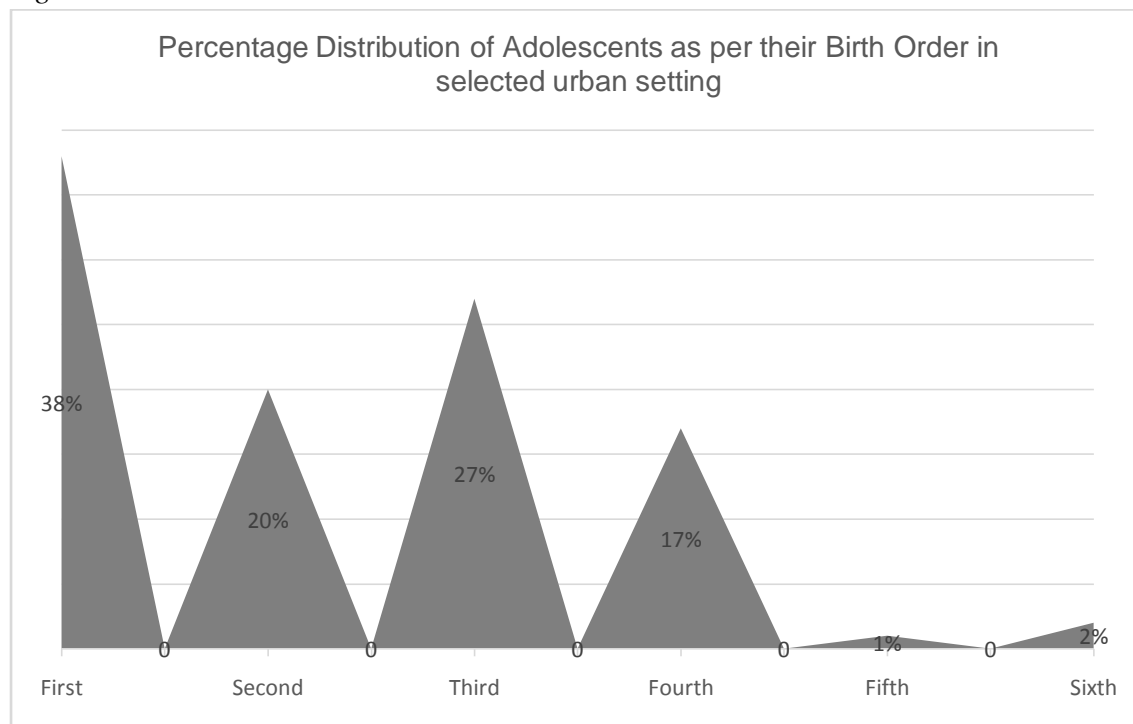
This area diagram shows that 17% of adolescents in rural setting were having their birth order as first, 27 % had second, 16% had third, 27% had fourth, 10% had fifth, and only 3% had sixth as their birth order.

Table 5.2 Table showing Frequency and Percentage distribution of adolescents as per their Family Income in selected urban setting.

Nu=100

Birth Order	Frequency	percentage
First	38	38 %
Second	20	20 %
Third	27	27 %
Fourth	17	17 %
Fifth	01	01 %
Sixth	02	02 %

Figure 5.2



This area diagram shows that 38% of adolescents in rural setting were having their birth order as first, 20% had second, 27% had third, 17% had fourth, 1% had fifth, and only 2% had sixth as their birth order.

Table 6.0 Table showing *Psycho-social problem score and percentage of adolescents in selected rural and urban setting.*

N=200

Psycho-social problem Score	Frequency (Percentage)	Mean	Standard Deviation	Range
1-35	97 (48.50%)	37.77	20.87	117-04
36-70	94 (47%)			
71-105	08 (04%)			
106-140	01 (0.50%)			

This table depicts that 48.50% of Adolescents were well adjusted while as 47% of Adolescents were having mild Psycho-Social problems, 04% had moderate Psycho-social problems and 0.5% had severe Psycho-social Problems. Thus in general the adolescents irrespective of their location had some Psycho-Social problems as is represented by the table above that constitute about 51.50% of total studied population and are said to be impaired while as 48.50% were well adjusted and are said to be not impaired.

Table 6.1 Table showing Psycho-social problem score and percentage of adolescents in selected rural schools.

Nr=100

Psycho-social problem Score	Frequency (Percentage)	Mean	Standard Deviation	Range
1-35	40 (40%)	40.75	20.02	86-04
36-70	55 (55%)			
71-105	05 (05%)			
106-140	0 (0%)			

This table depicts that 40% of Adolescents were well adjusted in the selected rural setting while as 55% of Adolescents were having mild Psycho-Social problems, 05% had moderate Psycho-social problems and 0% had severe Psycho-social Problems. Thus 60 % of Adolescents in selected rural schools were having Psycho-Social Problems and were said to be impaired and only 40% of the adolescents were well adjusted.

Table 6.2 Table showing Psycho-social problem score and percentage of adolescents in selected urban schools.

Nu=100

Psycho-social problem Score	Frequency (Percentage)	Mean	Standard Deviation	Range
1-35	57 (57%)	34.89	21.27	117-06
36-70	39 (39%)			
71-105	03 (03%)			
106-140	01 (01%)			

This table depicts that 57% of Adolescents were well adjusted in the selected urban setting while as 39% of Adolescents were having mild Psycho-Social problems, 03% had moderate Psycho-social problems and 01% had severe Psycho-social Problems. Thus 43% of Adolescents in selected urban schools were having Psycho-Social Problems and were said to be impaired and only 57% of the adolescents were well adjusted.

Hypothesis 1st

There is no significant difference in the mean levels of Psycho-social Problems among the adolescents of selected rural and urban schools.

Table 6.3

Category	N	Mean	SD &S _{EM}	S _{ED}	t-Test value	D.F	Significance Level(p)		Interpretation
Rural Adolescents	100	40.75	20.02 & 2.0	1.44	4.13	198	0.05	1.97	P<0.05 Significant
Urban Adolescents	100	34.80	21.27 & 2.1						

The above table shows that the t-value is 4.13 i.e. significant at the level 0.05 level and highly significant at 0.01 level hence the null hypothesis so proposed that there will be no significant difference between mean Psycho-social Problem score of adolescents in selected rural and urban schools is rejected. Moreover while comparing the means and percentage of the Psycho-social problem score of adolescents of rural (60%, 40.75) and urban schools (43%, 34.80) it can be concluded that adolescents of the selected schools living in the rural areas particularly those studied have more Psycho-Social Problems as compared to the Adolescents in the selected schools living in the urban areas of Kashmir valley.

Hypothesis 2nd

There is no significant difference in the mean levels of Psycho-social Problems among the female adolescents of selected rural and urban schools.

Table 6.4

Category	N	Mean	SD & S _{EM}	S _{ED}	t-Test value	D.F	Significance Level(p)		Interpretation
Rural Female Adolescents	50	48.10	19.81 & 2.8	2.76	2.76	98	0.05	1.97	P<0.05 Significant
Urban Female Adolescents	50	35.50	17.05 & 2.4						

The above table shows that the t-value is 2.76 i.e. significant at the level 0.05 level and hence the null hypothesis so proposed that there will be no significant difference between mean Psycho-social Problem score of female adolescents in selected rural and urban schools is rejected.

Hypothesis 3rd

There is no significant difference in the mean levels of Psycho-social Problems among the male adolescents of selected rural and urban schools.

Table 6.5

Category	N	Mean	SD & S _{EM}	S _{ED}	t-Test value	D.F	Significance Level(p)		Interpretation
Rural Male Adolescents	50	33.40	17.37 & 2.45	3.0	0.23	98	0.05	1.97	P>0.05 Not Significant
Urban Male Adolescents	50	34.40	17.37 & 3.0						

The above table shows that the t-value is 0.23 i.e. Not significant at the level 0.05 level and hence the null hypothesis so proposed that there will be no significant difference between mean Psycho-social Problem score of Male adolescents in selected rural and urban schools is accepted.

Hypothesis 4th

There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Age.

Table 6.6

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Age in Years							
12-14	09 [39.1%]	14	6.69	2	0.05	5.9	Significant
15-17	38 [70.37%]	[60.90%]					
18-20	13 [56.56%]	16 [29.62%] 10 [43.47%]					

The above table represents that there is significant association of age with Psycho-social problem score of rural adolescents as is depicted by value 6.69 which is <0.05 with degree of freedom 2. Thus the null hypothesis so proposed that there is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of age is rejected. This can be because with increasing age the role and status gets changed and there is always greater expectation from children by their parents. The future consciousness and the career development can also be a reason for the above mentioned finding.

Hypothesis 5th

There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Gender.

Table 6.7

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Gender							
Male	33 [44%]	28 [56%]	9.30	1	0.05	3.84	Significant
Female	37 [74%]	13 [26%]					

The above table represents that there is significant association between Psycho-social problems of male and female adolescents as calculated value is 9.30 that is $p < 0.05$ with 1 degree of freedom. Thus the null hypothesis so proposed that there is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of gender is

rejected. The females have more problem than males that can be due to strict norms, folkways, mores, tradition, life stress, less degree of empowerment and work overload in home and school, particularly in the rural areas.

Hypothesis 6th

There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Type of Family.

Table 6.8

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Type of Family							
Joint	15 [45.45%]	18 [54.54%]	4.34	1	0.05	3.84	Significant
Nuclear	45 [67.20%]	22 [32.80%]					

The above table represents that there is significant association of Type of Family with the Psycho-social problems of rural adolescents as $p < 0.05$. Thus the above null hypothesis is rejected. This can be due to disintegration of households in rural areas that is significant by the study as more Nuclear families are in the rural areas than the urban areas and is reverse of expected. Due to this the adolescents remain away from grandparental care and hence suffer more from problems.

Hypothesis 7th

There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Family Income.

Table 6.9

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Family Income							
1000-10,000	43 [65.15%]	23 [34.85%]	5.2	5	0.05	11.07	Not Significant
10,001-20,000	13 [54.16%]	11 [45.84%]					
20,001-30,000	04 [57.14%]	03 [42.86%]					
30,001-40,000	0 [0%]	03 [100%]					
40,001-50,000	0 [0%]	0 [0%]					
>50,000	0 [0%]	0 [0%]					

The above table shows that there is no significant association of family income with Psycho-social problems of rural adolescents. Thus the null hypothesis so proposed that there is no significant association of mean levels of Psycho-social problems of rural adolescent in terms

of Family Income is accepted. This can be due to limited needs and demands of adolescents of the rural areas and limited expenditures that are met with minimum amount of money. This can also be due to earning of small money by part time work (handicraft, knitting etc) or job for some pocket money and other items essential for them that are met by that amount.

Hypothesis 8th

There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Birth Order.

Table 6.10

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Birth Order							
1 st	09 [53%]	08 [47%]	3.76	5	0.05	11.07	Not Significant
2 nd	14 [52%]	13 [48%]					
3 rd	10 [59%]	07 [41%]					
4 th	20 [66.66%]	10 [33.33%]					
5 th	04 [66.66%]	02 [33.33%]					
6 th	03 [100%]	0 [0%]					

The above table shows that birth order does not have significant association with Psycho-social problems of adolescent in the selected rural schools. This can be due to equal treatment of children irrespective of their birth order. Thus the above proposed null hypothesis is accepted.

Hypothesis 9th

There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Age.

Table 6.11

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Age in Years							
12-14	0 [0%]	14 [100%]	28.8	2	0.05	3.84	Significant
15-17	22 [36%]	39 [64%]					
18-20	21 [84%]	04 [16%]					

The table shows that there is significant association of age with Psycho-social problems as chi square value is 28.8 that is significant at 0.05 and highly significant at 0.01 significance level. Thus the above stated null hypothesis so stated that there is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of age is rejected. The results so obtained can be due changing role and status of adolescents, career focused, futuristic behavior, changes in physical appearance, demanding parents and relatives, stress etc.

Hypothesis 10th

There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Gender.

Table 6.12

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Gender							
Male	21 [42%]	29 [58%]	0.04	1	0.05	3.84	Not Significant
Female	22 [44%]	28 [56%]					

This table depicts that there is no association of gender with psycho-social problems as $p > 0.05$ level. Thus the null hypothesis so proposed is accepted. This can be due more autonomy or empowerment and involvement of female adolescents in the family affairs. The females in urban areas are thought to be at par with male children.

Hypothesis 11th

There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Type of Family.

Table 6.13

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Type of Family							
Joint	23 [46%]	27 [54%]	0.36	1	0.05	3.84	Not Significant
Nuclear	20 [40%]	30 [60%]					

The above table depicts that there is no significant association of Type of Family with the Psycho-social problems of urban adolescents. Thus the above stated null hypothesis is accepted. The results so obtained can be due to existence of more joint family system in which grandparents provide support and care to adolescents; in city as compared to rural areas.

Hypothesis 12th

There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Family Income.

Table 6.14

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Family Income							
1000-10,000	27 [71%]	11 [29%]	21.6	5	0.05	11.07	Significant
10,001-20,000	03 [33.33%]	06 [66.66%]					
20,001-30,000	08 [30.80%]	18 [69.20%]					
30,001-40,000	04 [23.50%]	13 [76.50%]					
40,001-50,000	0 [0%]	05 [100%]					
>50,000	01 [20%]	04 [80%]					

The above table represents that there is significant association of Family income with Psycho-social problem score of urban adolescents as calculated value is 21.6 that is significant at 0.05 level with 5 degree of freedom. Thus the null hypothesis so proposed that there is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Family Income is rejected. This can be due to increasing demands of the adolescent that remain unmet due to limited income and support of large family, siblings,

limited influx of money to adolescents so that they cannot indulge in self-destructive activities.

Hypothesis 13th

There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Birth Order.

Table 6.15

Socio-demographic data	Impaired	Not impaired	X ² value	D.F	Significance level (p)		Interpretation
Birth Order							
1 st	14 [37%]	24 [63%]					
2 nd	08 [40%]	12 [60%]					
3 rd	12 [44.40%]	15 [55.60%]	4.55	5	0.05	11.07	Not Significant
4 th	07 [58.33%]	05 [41.66%]					
5 th	01 [100%]						
6 th	01 [50%]	0 [0%] 01 [50%]					

The above table shows that birth order does not have any significant association as $p > 0.05$ with Psycho-social problems of adolescent in the selected urban schools. Thus the null hypothesis so proposed that there is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Birth Order is accepted. This can be due to equal love and support to each and every children irrespective of birth order and joint family system as is more prevalent in city as compared to rural areas of Kashmir.

DISCUSSION

The results of the study has been easily depicted by the tables and figures. These were obtained by using descriptive and inferential statistics. Now let us examine the results of the study briefly and let us start from the baseline characteristics of adolescents of selected rural areas.

The study has revealed that highest number of adolescents in selected rural and urban schools i.e 57.50% belonged to age group of 15-17 years of age, 24% of adolescents belonged to age group of 18-20 years while as 18.5% adolescent study population belonged to 12-14 years of age.

The findings has shown that 35% of the adolescents in the rural area were in the age group of 12-14 years among whom 13 members were male and 22 were female adolescents. It was also seen that 42% of respondents were in the age group of 15-17 years, comprising majority age group in the selected rural schools. Out of these 25 respondents were male and 17 were female. About 23% of the respondents belonged to the age group of 18-20 years among whom 12 were males and 11 were females. The findings have also revealed that 14% of the adolescents in selected urban schools were in the age group of 12-14 years among whom 08 members were male and 06 were female adolescents. It was also seen that 61% of respondents were in the age group of 15-17 years, comprising majority age group in the selected rural schools. Out of these 30 respondents were male and 31 were female. About 25% of the respondents belonged to the age group of 18-20 years among whom 12 were males and 13 were females.

As was proposed earlier in the synopsis that boy and girl adolescents would be equally the part of this study so that approach was carried out. Both male and female adolescents were equally part of it. Here in the study 50% of respondents were male and 50% were female. So the number of males was 100 and 100 were the females, making a total of 200 study samples. Out of 100 males 50 belonged to selected rural schools and 50 belonged to the selected urban schools. Same was the case with female adolescents.

The study has revealed that maximum number (58.5%) of adolescents are living in Nuclear families in rural and urban setting while as only 41.5% adolescents responded that they are living in joint families. The findings had also revealed that 33% of the respondents were living in the Joint family in the selected rural schools and maximum of respondents that is 67% were living in the Nuclear families. This has shown that the living style is changing in the rural areas and household is disintegrating and separation from other family members and establishing a new small family is apparent from this finding. The support group in the families in the form of grandparents and other significant others is decreasing, that in one or the other way leads to deterioration of mental and social health thus leading to Psycho-Social problems in the younger generations particularly children and adolescents. As per the data collected and analyzed it was observed that 50% of the adolescent living in the urban areas were living in joint families and rest of the 50% were living in nuclear families. Thus it was seen that nuclear families are nowadays a fashion and trend that has erupted in the rural areas of Kashmir to greater extent. This could be probably due to changing beliefs, values, changing customs and traditions, demand of independence by younger generation, share in property etc.

This study has revealed that 52% of adolescents have low family income ranging in between 1000-10,000 rupees a month followed by 16.50% in the range of 10,001-20,000 and 20,001-30,000 each. The adolescents (10%) who were part of this research project and living in Kashmir valley has depicted their family income ranges in between 30,001-40,000 while as 2.5% adolescents have 40,001-50,000 and above 50,000 family income in each group. Thus the findings has also revealed that maximum of the adolescents that means about 69% belonged to the family income group earning in between 1000-10,000 rupees a month in the

selected rural schools. Among them 38 male respondents belonged to this group and 31 females were part of this income group. The findings has also revealed that about 20% respondents [07 males and 13 females] were having their family income in between 10,001-20,000. The study has also depicted that about 07% respondents [01 male and 06 females] has their family income in between 20,001-30,000 per month. The study also confirmed that the family income of 4% respondents that too males have in between 30,001-40,000 and there were no respondents whose family income was greater than 40,000 per month. This means that majority of the adolescents in the selected rural schools belong to low income group. The findings has also revealed that maximum of the adolescents that means about 38% belonged to the family income group earning in between 1000-10,000 rupees a month in the selected rural schools. Among them 20 male respondents belonged to this group and 18 females were part of this income group. The findings has also revealed that about 09% respondents [06 males and 03 females] were having their family income in between 10,001-20,000. The study has also depicted that about 26% respondents [12 male and 14 females] has their family income in between 20,001-30,000 per month. The study also confirmed that the family income of 17% of respondents have in between 30,001-40,000 out of which 07 were males and 10 were female adolescents. There were only 05% respondents whose family income was in between 40,001-50,000 rupees per month out of whom 02 were males and 03 were females. There were 5% of respondents whose family income was above 50,001 rupees among whom 03 were male adolescents and 02 were female adolescents.

In this research, the researcher have found that 27.50% adolescents in selected schools of Kashmir valley had birth order 1st, 23.50% had 2nd as birth order, 22% had 3rd, 21% had 4th, 3.50% had 5th and 2.50% had 6th. The findings has also revealed that 17% of the respondents in the selected rural setting were having 1st as their birth order. Among them 09 were male respondents and 08 respondents were female. The 2nd birth order was declared by 27% of the respondents in the rural setting among whom 09 were males and 18 were females. 16% of the adolescent belonged to birth order of 3rd among whom 11 were males and 05 were females. The findings has also depicted that 27% adolescents belonged to birth order 4th out of which 13 respondents were males and 14 were females. Moreover 10% of the respondents in the selected rural schools were having birth order 5th from which 08 were males and 02 females. Only 3% of the respondents marked 6th as their birth order all of whom were females. The findings has also revealed that 38% of the respondents in the selected urban setting were having 1st as their birth order. Among them 14 were male respondents and 24 respondents were female. The 2nd birth order was declared by 20% of the respondents in the urban setting among whom 10 were males and 10 were females. 27% of the adolescent belonged to birth order of 3rd among whom 17 were males and 10 were females. The findings has also depicted that 12% adolescents belonged to birth order 4th out of which 07 respondents were males and 05 were females. Moreover 1% of the respondents in the selected rural schools were having birth order 5th who was a female. Only 2% of the respondents marked 6th as their birth order both of whom were males.

The study has revealed that 48.50% of Adolescents were well adjusted while as 47% of Adolescents were having mild Psycho-Social problems, 04% had moderate Psycho-social

problems and 0.5% had severe Psycho-social Problems. Thus in general the adolescents irrespective of their location had some Psycho-Social problems as is represented by the table above that constitute about 51.50% of total studied population and are said to be impaired while as 48.50% were well adjusted and are said to be not impaired. The mean psycho-social problem score obtained by adolescents was 40.75 while as score range was 04-117. The study also made this revelation that 40% of Adolescents were well adjusted in the selected rural setting while as 55% of Adolescents were having mild Psycho-Social problems, 05% had moderate Psycho-social problems and 0% had severe Psycho-social Problems. Thus 60 % of Adolescents in selected rural schools were having Psycho-Social Problems and were said to be impaired and only 40% of the adolescents were well adjusted. This piece of research has also discovered that 57% of Adolescents were well adjusted in the selected urban setting while as 39% of Adolescents were having mild Psycho-Social problems, 03% had moderate Psycho-social problems and 01% had severe Psycho-social Problems. Thus 43% of Adolescents in selected urban schools were having Psycho-Social Problems and were said to be impaired and only 57% of the adolescents were well adjusted. There was significant difference between mean Psycho-social problem score of rural and urban adolescents and for this, the t-value is 4.13 i.e. significant at the level 0.05 level and highly significant at 0.0. This could be due to low economic status, needs and demands from the parents, career consciousness, undue pressures from parents and teachers, work-overload in home and schools etc.

There was significant difference between mean psychosocial problem score of rural and urban female adolescents, where the t-value is 2.76 [i.e. significant at the level 0.05] that can be due to conservative society in rural areas, less economic and social freedom for women, less independence to female adolescents to take their own decisions, Family conditions and patriarchal family systems and even type of families.

The study has shown that there is association of age, gender and type of Family with Psycho-social Problems of the adolescents living in the rural area as has been depicted by the table 6.4. This association could be due changing characteristics of the adolescents who tend to enter adulthood and expectations from him or her tend to increase continuously with the increasing age. The females are not allowed to decide their about their future, are dependent on family decisions, enjoy less independence, rules are for them, and even are asked to follow what are dictated most of the times so the results might be like this that they are at more risk of developing psycho-social problems as compared to male adolescents.

While as in case of urban adolescent's age and Family Income has significant association with the Psycho-social Problems. With increasing age the needs and demands also increases, role and status gets changed, physical and mental development occurs, there arises a need for belongingness and love, age of gang formation approaches, poverty, no friend circle, less pocket money, support to large family, siblings, grandparents, outing etc thus in order to tackle all of these scenarios, psychosocial problems may be the outcome. It is worth to record here that there is significant difference between psychosocial problems of Urban and rural

female adolescents while as there is no difference between adolescent males of selected rural and urban schools as depicted by table 6.6 and table 6.7.

The results of this study are comparable with the studies carried out by Shankar B, Ahmad A, who used youth report of pediatric symptom checklist and general health questionnaire respectively. The results are also comparable with the study carried out by Waseem K and Firdous W.

CHAPTER: V

SUMMARY, CONCLUSION AND RECOMMENDATIONS

SUMMARY AND CONCLUSION:

Statement of the problem:

A comparative study to assess Psycho-social Problems of adolescents between selected Rural and Urban schools of Kashmir.

Objectives:

1. To assess the Psycho-social Problems among adolescents of selected rural schools using Youth Self Report.
2. To assess the Psycho-social Problems among adolescents of selected urban schools using Youth Self Report.
3. To Compare the Psycho-social Problems between adolescents of rural and urban schools.
4. To find the association between Psycho-social Problems of rural school adolescents and socio-demographic data.
5. To find the association between Psycho-social Problems of urban school adolescents and socio-demographic data.

Hypothesis

H₁: There is no significant difference in the mean levels of Psycho-social Problems among the adolescents of selected rural and urban schools.

H₂: There is no significant difference in the mean levels of Psycho-social Problems among the female adolescents of selected rural and urban schools.

H₃: There is no significant difference in the mean levels of Psycho-social Problems among the male adolescents of selected rural and urban schools.

H₄: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of age.

H₅: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of gender.

H₆: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Type of Family.

H₇: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Family Income.

H₈: There is no significant association of mean levels of Psycho-social problems of rural adolescent in terms of Birth Order.

H₉: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of age.

H₁₀: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of gender.

H₁₁: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Type of Family.

H₁₂: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms of Family Income.

H₁₃: There is no significant association of mean levels of Psycho-social problems of urban adolescent in terms Birth Order.

Delimitation

The study is limited to;

1. Adolescents who are studying in the selected rural and urban schools of Kashmir.
2. Students studying in 8th, 9th, 10th, 11th and 12th standards.
3. Schools of district Baramulla and Srinagar.

Methodology

In this study descriptive research design was selected. The study was carried out in selected rural and urban secondary and senior secondary schools of Kashmir. The population of the study were the adolescents and the sample were adolescents studying in those selected schools. The sample size was 200. The samples were selected by convenient sampling method.

Findings of the study

1. There is significant difference in the mean Psycho-social Problem scores between the adolescents of selected rural and urban schools.
2. There is significant difference in the mean Psycho-social Problem scores between the female adolescents of selected rural and urban schools.
3. There is no significant difference in the mean Psycho-social Problem scores between the male adolescents of selected rural and urban schools.
4. There is significant association of Psycho-social problems of rural adolescent with age.
5. There is significant association of Psycho-social problems of rural adolescent with gender.
6. There is significant association of Psycho-social problems of rural adolescent with Type of Family.
7. There is no significant association of Psycho-social problems of rural adolescent with Family Income.
8. There is no significant association of Psycho-social problems of rural adolescent with Birth Order.
9. There is significant association of Psycho-social problems of urban adolescent with age.
10. There is no significant association of Psycho-social problems of urban adolescent with gender.
11. There is no significant association of Psycho-social problems of urban adolescent with Type of Family.
12. There is significant association of Psycho-social problems of urban adolescent with Family Income.
13. There is no significant association of Psycho-social problems of urban adolescent with Birth Order.

Educational Implications of the Findings:

The findings of the study have some educational implication some are as follows:

1. The Psycho-Social Problems are present in the adolescents of the selected schools in the vale as was depicted by the results of this research and affects both boys and girls in both urban and rural areas of Kashmir. The implication of this is that there is more desire for independence, search of identity, search for goal, sexual identity, cooperative activities with same and opposite sex, building trusting relationships,
2. As there is no provision for some Mental Health Professionals in the schools of Kashmir, this becomes another implication that there should be the availability of Professionals like Psychologists or Psychotherapists or Counsellors or School Health Nurses for the effective implementation of counseling strategies to be used in solving the problem of adolescents. Thus the said Professionals should be employed and said posts should be created in the schools to help adolescents in solving their problems, monitoring their growth and development, giving them solutions to their problems, referral to adequate and accurate health care facility at the time of need.
3. Standards of education in the government run schools to be increased as adolescents in the secondary schools were unable to understand the statements on their own, who were later on made understand by translating the statements in Urdu and Kashmiri.

Conclusion:

Adolescents living in the rural and urban areas of Kashmir valley have psycho-social problems. However those living in rural setting are more prone to it. Female adolescents (74%) of rural areas are more affected than male adolescents (44%) while as male and female adolescents in urban setting were equally affected. In the selected rural and urban schools of Kashmir Psycho-social problems in adolescents increase with age and are more in the age group of 15-17 years. Low economic status also add to the Psycho-social problems in the urban areas as proved statistically. Type of family also affects the adolescents as in rural area about 67.20% impaired were hailing from nuclear family while as in urban area it has shown no association.

Strengths and Limitations of the Study:

This study was first of its kind in the valley of Kashmir as far as literature was available. However the study was carried out in few selected schools, run under government and private managements in Kashmir valley. In government run schools it was difficult to collect data from adolescents studying in the 8th, 9th and 10th standards as they were not able to get the youth self-report scale and thus each statement was explained in Urdu and even in their mother tongue both in the rural and urban areas. However the adolescents studying in the schools run under private management were able to respond to statements of the youth self-report scale themselves and there was no need to explain it or translate the same in any other language. In this study it was difficult to find out factors affecting to adolescents leading to Psycho-Social Problems. Some of the school principals in the urban areas hesitated to provide permission for data collection and hence were not included.

Suggestions for further Research:

During this period of study, it has been observed that there is more scope for further research in this field or the problem. The future researchers can incorporate the following suggestions in their studies. These are as follows;

1. The study should be repeated on a larger scale involving all the districts of Kashmir valley with a bigger sample size.
2. The study can be repeated with a modified or translated youth self-report scale most probably in the Urdu language that each and every adolescent can understand so that to minimize the data collection time and there would be no need to explain the statements of the scale.
3. The study could be repeated on the adolescents who do not go to schools and have left their education half way because of the various reasons that too need to be evaluated.
3. Another study could be carried out to investigate the role of the teachers in the secondary and senior secondary school schools to address the Psycho-Social Problems of adolescents.
4. The study can be repeated by adding more socio-demographic variables like type of school management, education medium, religion, family members etc and evaluating their association with Psycho-social problems of adolescents.
5. Another study could be carried out to investigate the need and place of Psychologists /Psychotherapists /Counsellors/School Health Nurses in the secondary and senior secondary school system.
6. The causes of the Psycho-social problems in the adolescents need to be explored in the future researches and strategies used by the adolescents to overcome those need to be studied.

Recommendations:

After this whole process of data collection and analysis and even beyond that the results that have been obtained, I have to recommend following points that we all –parents, adolescents, governmental agencies and all other associated persons and organisations have to consider. These recommendations are as:

1. Trained Counselors or Psychologists or School Health Nurses or Psychotherapists should be employed in secondary and senior secondary schools to help adolescents so that they can solve their Psycho-social problems.
2. The curriculum should be expanded to cover such topics in schools drug education, human development, gender roles, career opportunities. Problem solving method should be adopted to enable the children develop sense of identity.
3. We should avoid destructive criticism or simply Negative criticism of the adolescent potentials and capabilities. We should make the adolescent feel that they are being loved by one and all in the family and school and has their own individual identity.
4. The Counsellor or Psychologists or school Health Nurse or Psychotherapist along with the teachers should organize co-operative organization such as group games, group discussion, debates, role play, dramas and other extra-curricular activities for the adolescents so that to enable them to interact with same sex, opposite sex, peer group and maintain close relationship with all, thus live in harmonious relationship with each other. There should be health seminars in every community so that to enable parents and other significant others of

the adolescents to know the need for proper growth and development of the adolescents, their needs and demands, wishes and wants so that they can maintain optimal state of health.

5. Adolescent friendly environment should be prepared in home and schools so that to preserve the health of our future generation, decreasing the generation gaps by allowing adequate degree of freedom and guidance of adolescents by parents and grandparents by life experiences.

6. Counseling Strategies should be used by the professionals in solving Psycho-social Problems of the Adolescents. The following counselling strategies are used to solve the problems of adolescents. Cognitive restructuring is a techniques designed to help the counselee to know himself and his environment so that he/she might act more appropriately in future problem. Thus it attempts to reduce negative emotional reactions by getting adolescents to interpret situation with greater accuracy.

In Group Counseling the adolescents receives attention assurance and support from one another as well as from the counselor, this has a therapeutic effect as the adolescents begin to identify with one another and become increasingly aware of the similarities of their problems and concerns. Adolescent with the problems of homosexuality, premarital problems, those suffering from neurosis and those fairly disturbed, anxiety and hostility.

Role Playing and Modeling is the other strategy to help adolescent to solve their problems. This is used to show the adolescents how to think and behave differently. Role play is a method which involves modeling and is used when the counselee has an interpersonal problem with a significant person in his /her life and therefore has to learn to behave different towards such persons. Role play is effective in training a client to be assertive, to overcome shyness, stage freight, aggressiveness, and deal with different situations. The adolescent is made to practice or rehearse the behavior he/she wants to learn several times by imagining the presence of the person (significance order) with him Omebe (2004).

Reinforcement Strategies can be used by the counselor or Psychotherapist or Psychologist for the treatment of drug addict and alcoholism individual. Excessive behaviors like drug addict alcoholism, aggression, Stealing, smoking, bullying, anger adolescents can be modified by the counselor through reinforcement and cognitive learning strategies. Positive reinforcement when presented, increase the behavior while negative reinforcement strengthens behavior by removing the negative Stimuli. Cognitive learning is used where the client knows the desirable behavior but does not know how to acquire it. The counsellor should provide suggestion to the adolescent so that it can be carried out to overcome a problem. Cognitive learning gives the adolescent basis for making decisions, developing his value judgment and forming concept about himself.

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APPENDICES

“A COMPARATIVE STUDY TO ASSESS THE PSYCHO-SOCIAL PROBLEMS AMONG ADOLESCENTS OF SELECTED RURAL AND URBAN SCHOOLS OF KASHMIR”

PART I:

Dear participant, please provide the following baseline data regarding yourself by accepting to be a part of this research project. The information that will be provided by you will be kept confidential and will be used for research purpose only.

BASELINE DATA:

Age

Gender

Type of family

Family income

Birth order

PART II:

Self-reported scale on psychosocial problems of adolescents

Instructions to the participants:

Dear participants, please read the statements carefully. For each item that describes you, please put (√) mark for Never, Sometimes, and often in the appropriate columns. There is no right or wrong answer for these statements. The information provided by you will be kept confidential.

S.NO.	CONTENT	NEVER 0	SOMETIMES 1	OFTEN 2
1	I am too fearful or anxious			
2	I bite my fingernails			
3	I feel awkward in front of others			
4	I feel nervous in front of other people			
5	I am afraid that I might think or do something bad			
6	When I have a problem, I get a funny feeling in my stomach			
7	I feel afraid that I will make a fool out of myself in front of people			
8	I feel scared if I have to sleep on my own			
9	When I have a problem I feel shaky			
10	I am scared of being in high places or in lifts			

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Schools of Kashmir

S.NO.	CONTENT	NEVER 0	SOMETIMES 1	OFTEN 2
11	I am afraid about what will happen in the future			
12	I am afraid of new situations			
13	I feel worthless or inferior			
14	I feel hopeless about the future			
15	I do not have much energy and feel tired			
16	I deliberately try to harm or hurt or kill myself			
17	I am unhappy or sad			
18	I cry a lot			
19	I feel lonely			
20	I feel my life has been a failure			
21	I am unable to enjoy life			
22	I have trouble keeping my mind on what I am doing			
23	I don't feel like eating			
24	I feel that no one loves me			
25	I act too young for my age			
26	I am jealous of others			
27	I feel too guilty			
28	I wish I had someone whom I could tell my problems			
29	I am suspicious			
30	I am stubborn			
31	I am too shy or timid			
32	I get hurt easily			
33	I am not able to express my feeling to othes			
34	I do not understand other's feelings			
35	I am too much dependent on others			
36	I day dream a lot			
37	I steal at home			
38	I steal from places other than home			
39	I tell lies to others			
40	I get into many fights			
41	When I am angry, I destroy things belonging to others			
42	I feel like running away from home			
43	I stay out of my house at night without permission of my parents			
44	I don't feel guilty after doing something I should not			
45	When I am angry, I destroy my own things			
46	I argue a lot with others			
47	I bunk my classes			
48	My school performance is poor			
49	I have problems with teacher			

S.NO.	CONTENT	NEVER 0	SOMETIMES 1	OFTEN 2
50	I am absent from school			
51	I have trouble concentrating or paying attention in the class			
52	I don't get along with my classmates			
53	I am afraid of going to school			
54	I disobey in school			
55	I am unhappy with my friends			
56	I have trouble sitting still at one place			
57	I think of sex a lot			
58	I act before thinking			
59	I disobey my parents			
60	I read books/magazines/sites on sex			
61	I drink alcohol without information of my parents			
62	I smoke /chew tobacco			
63	I smoke when I am alone at home			
64	I use drugs for non-medical use			
65	I have friends who use drugs for non-medical purposes			
66	I smoke to fit in the peer group			
67	I am afraid of getting caught for smoking by my parents			
68	I am afraid of getting caught for drinking alcohol by my parents			
69	I get in trouble because of using drugs in school			
70	I get in trouble in school because of my smoking habit			

Answer key-self reported psychosocial problem scale:

Scoring key;

Often =2

Sometimes=1

Never =0

Total score: 70 X 2 =140

All the statements are negatively stated.

The score is arbitrarily classified as follows;

0-35: well adjusted

36-70: mild psychosocial problem

71-105: moderate psychosocial problem

106-140: severe psychosocial problem

STATISTICAL FORMULA USED

$$\text{Mean} = \frac{\sum f.x}{\sum f}$$

$$\text{Standard Deviation} = \sqrt{\frac{\sum f.x^2}{\sum f} - \left(\frac{\sum f.x}{\sum f}\right)^2}$$

$$\text{Range} = H-L$$

$$\text{T Test} = \frac{\bar{X}_1 - \bar{X}_2}{S_{ED}}$$

$$\chi^2 = \sum \frac{[O-E]^2}{E}$$



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